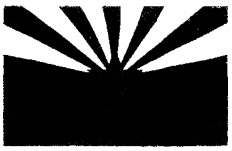
State by state...There's a way

ALABAMA
Sign on the right—
"Dispense as Written" line

ALASKA
"Dispense as Written"

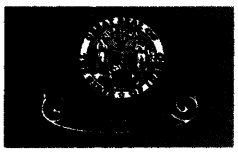


ARIZONA
Sign on the left—
"Dispense as Written" line

ARKANSAS
"Dispense as Written"

CALIFORNIA
"Do Not Substitute"

HAWAII
"Do Not Substitute"



IDAHO
Sign on the right—
"Dispense as Written" line

ILLINOIS
Check box— ☐
"May Not Substitute"

INDIANA
Sign on the left—
"Dispense as Written" line

IOWA
"No Substitution"
or "D.A.W."

MASSACHUSETTS
"No Substitution"

MICHIGAN
"Dispense as Written"

MINNESOTA
"Dispense as Written"

MISSISSIPPI
"Dispense as Written"

MISSOURI
Sign on the right—
"Dispense as Written" line

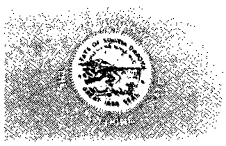
NEW MEXICO
"No Substitution"

NEW YORK
Write "D.A.W." in box

NORTH CAROLINA
Sign on the right—
"Dispense as Written" line

NORTH DAKOTA
Sign on the right—
"Dispense as Written" line

OHIO
"Dispense as Written"



SOUTH DAKOTA
Sign on the right—
"Dispense as Written" line

TENNESSEE
Sign bottom line—
"Dispense as Written"

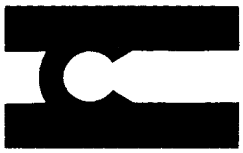
TEXAS
Sign on the right—
"Dispense as Written" line

UTAH
"Dispense as Written"

VERMONT
"No Substitution"

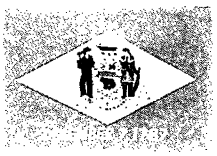
Make it your way to specify

to "flag" your prescription...



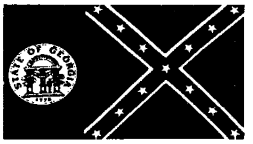
COLORADO
"Dispense as Written"

CONNECTICUT
"No Substitution"



DELAWARE
Sign top line—
"Dispense as Written"

FLORIDA
"Medically Necessary"

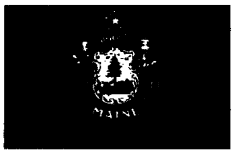


GEORGIA
"Brand Necessary"

KANSAS
"Dispense as Written"

KENTUCKY
"Do Not Substitute"

LOUISIANA
"No Substitution" or
"Dispense as Written"

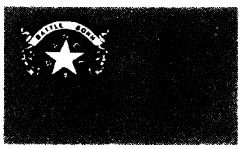


MAINE
Check box— ☐
"Do Not Substitute"

MARYLAND
"Do Not Substitute"

MONTANA
"Medically Necessary"

NEBRASKA
"No Drug Product Selection"
or "N.D.P.S."



NEVADA
Check box— ☐
"Dispense only as Written"

NEW HAMPSHIRE
"Medically Necessary"

NEW JERSEY
Initial on the right—
"Do Not Substitute" line

OKLAHOMA
"Do Not Substitute"

OREGON
"No Substitution"

PENNSYLVANIA
Sign on the left—
"Do Not Substitute" line

RHODE ISLAND
"Dispense as Written" line

SOUTH CAROLINA
Sign on the left—
"Dispense as Written" line

VIRGINIA
Sign on the right—
"Dispense as Written" line

WASHINGTON
Sign on the right—
"Dispense as Written" line

WEST VIRGINIA
Sign on the left—
"Brand Necessary" line

WISCONSIN
"No Substitution"

WYOMING
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They wondered how our legal counsel did it.

But now the jury's in.

The real test of professional liability protection is what happens if a claim is made against you.

After all, that's what you're paying for.

Compare the Cost Savings Between Insurance Carriers and the Cooperative of American Physicians/Mutual Protection Trust (CAP/MPT) for $1,000,000–$3,000,000 Coverage.

	Southern California			Northern California		
Specialty	Composite* Insurance Companies	CAP/MPT	Savings with CAP/MPT	Composite* Insurance Companies	CAP/MPT	Savings with CAP/MPT
Psychiatry	$ 5,100	$ 2,365	54%	$ 3,789	$ 2,052	46%
Pediatrics	7,357	2,365	68%	6,208	2,052	67%
Urology	18,571	13,735	26%	14,560	11,776	19%
Anesthesiology	19,704	13,735	30%	16,299	11,776	28%
General Surgery	30,841	17,853	42%	22,388	15,306	32%
Plastic Surgery	31,557	17,853	43%	22,961	15,306	33%
Orthopedic Surgery w/Spinal	39,744	21,971	45%	34,184	18,837	45%
Obstetrics/ Gynecology	49,812	21,971	56%	40,220	18,837	53%

* Insurance company composite rates are averages based upon 4/1/88 rates of The Doctors' Company, 6/1/87 rates of MIEC, 1988 rates of Norcal and SCPIE. Details of source data on request. No costs shown here for San Diego or Imperial County. Other surcharges, credits, reductions may apply. All costs based on mature rate (including retroactive coverage).

CAP/MPT costs are based on dues and January 1988 mature assessments. They do not include the $200 membership fee and refundable initial trust contribution amounts.

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Call for the cost for your specific specialty.

Our management of malpractice claims is rated among the best by our own CAP/MPT physician-members. 96% report that they were well satisfied with the claim service, and 70% cited our service as "outstanding."

This satisfaction is due to:

- Our "dedicated" law firm which is devoted 100% to CAP/MPT members and medical malpractice issues;
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- A most diligent process of claims review involving extensive medical, legal, and professional specialists for each claim;
- A company commitment to judging each case on its individual merits; we do not hesitate to litigate when appropriate in a non-meritorious case.
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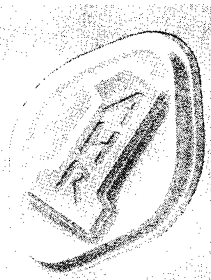
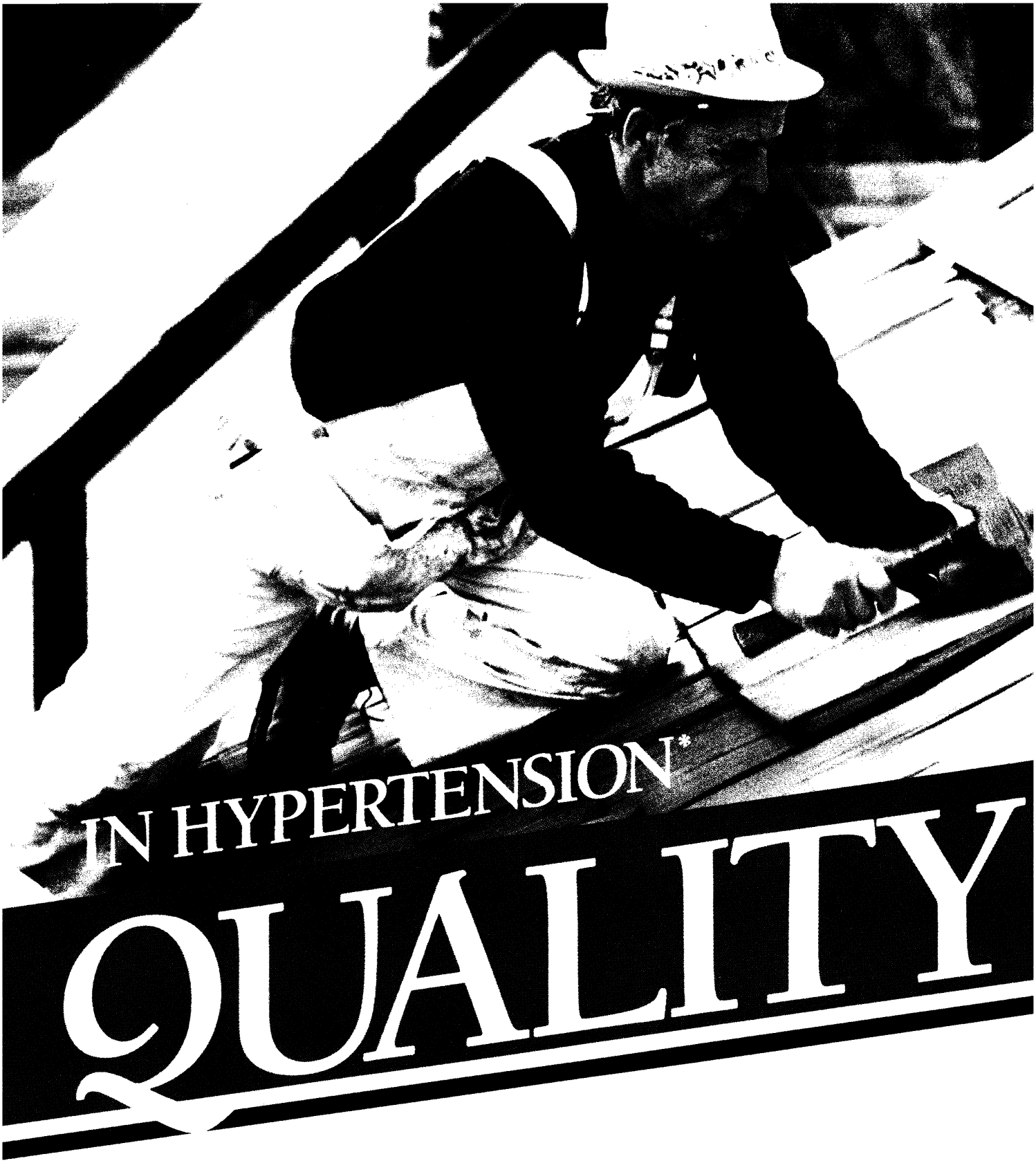


TENEX®

(Guanfacine HCl)

A·H·ROBINS Pharmaceutical Division, Richmond, Virginia 23261-6609



***CAPOTEN® (captopril tablets) may be used as initial therapy only for patients with normal renal function in whom the risk of neutropenia/agranulocytosis is relatively low (1 out of over 8,600 in clinical trials). Use special precautions in patients with impaired renal function, collagen vascular disorders, or those exposed to other drugs known to affect the white cells or immune response. Evaluation of hypertensives should always include assessment of renal function. Overall, the most frequently occurring adverse reactions associated with CAPOTEN are skin rash and taste alteration; both effects are generally mild, reversible, or self-limited. See INDICATIONS AND USAGE, WARNINGS, and ADVERSE REACTIONS in the brief summary on the adjacent page.**

1. Croog SH, Levine S, Testa MA, et al: The effects of antihypertensive therapy on the quality of life. N Engl J Med 314(26):1657-1664, 1986.

SQUIBB

Means a job well done.

We spend so much of our lives at work...it's no wonder our work performance is key to our quality of life. Work performance is also a key factor in assessing antihypertensive therapy. CAPOTEN improved hypertensive patients' work performance (e.g., ability to keep pace with the job, concentration, job satisfaction, less on-the-job fatigue).[1] So, for hypertensive patients who work, why not prescribe the antihypertensive that can work for them...

These data are based on a multicenter, randomized, 24-week study of 626 mild-to-moderate hypertensive male patients with normal renal function, 181 of whom received captopril.

OF LIFE

THE CAPOTEN® (captopril tablets) DIFFERENCE

QUALITY OF LIFE THE CAPOTEN® (captopril tablets) DIFFERENCE

CAPOTEN® TABLETS
Captopril Tablets

INDICATIONS: Hypertension – CAPOTEN (captopril) is indicated for the treatment of hypertension. Consideration should be given to the risk of neutropenia/agranulocytosis (see WARNINGS). CAPOTEN may be used as initial therapy for patients with normal renal function, in whom the risk is relatively low. In patients with impaired renal function, particularly those with collagen vascular disease, captopril should be reserved for those who have either developed unacceptable side effects on other drugs, or have failed to respond satisfactorily to drug combinations. CAPOTEN is effective alone and in combination with other antihypertensive agents, especially thiazide-type diuretics.

Heart Failure: CAPOTEN (captopril) is indicated in patients with heart failure who have not responded adequately to or cannot be controlled by conventional diuretic and digitalis therapy. CAPOTEN is to be used with diuretics and digitalis.

CONTRAINDICATIONS: CAPOTEN is contraindicated in patients who are hypersensitive to this product.

WARNINGS: Neutropenia/Agranulocytosis – Neutropenia ($<1000/mm^3$) with myeloid hypoplasia has resulted from use of captopril. About half of the neutropenic patients developed systemic or oral cavity infections or other features of the syndrome of agranulocytosis. The risk of neutropenia is dependent on the clinical status of the patient:

In clinical trials in patients with hypertension who have normal renal function (serum creatinine less than 1.6 mg/dL and no collagen vascular disease), neutropenia has been seen in one patient out of over 8,600 exposed. In patients with some degree of renal failure (serum creatinine at least 1.6 mg/dL) but no collagen vascular disease, the risk in clinical trials was about 1 per 500. Doses were relatively high in these patients, particularly in view of their diminished renal function. In patients with collagen vascular diseases (e.g., systemic lupus erythematosus, scleroderma) and impaired renal function, neutropenia occurred in 3.7% of patients in clinical trials. While none of the over 750 patients in formal clinical trials of heart failure developed neutropenia, it has occurred during the subsequent clinical experience. Of reported cases, about half had serum creatinine ≥ 1.6 mg/dL and more than 75% received procainamide. In heart failure, it appears that the same risk factors for neutropenia are present.

Neutropenia has appeared usually within 3 months after starting therapy, associated with myeloid hypoplasia and frequently accompanied by erythroid hypoplasia and decreased numbers of megakaryocytes (e.g., hypoplastic bone marrow and pancytopenia); anemia and thrombocytopenia were sometimes seen. Neutrophils generally returned to normal in about 2 weeks after captopril was discontinued, and serious infections were limited to clinically complex patients. About 13% of the cases of neutropenia have ended fatally, but almost all fatalities were in patients with serious illness, having collagen vascular disease, renal failure, heart failure or immunosuppressant therapy, or a combination of these complicating factors. **Evaluation of the hypertensive or heart failure patient should always include assessment of renal function.** If captopril is used in patients with impaired renal function, white blood cell and differential counts should be evaluated prior to starting treatment and at approximately 2-week intervals for about 3 months, then periodically. In patients with collagen vascular disease or who are exposed to other drugs known to affect the white cells or immune response, particularly when there is impaired renal function, captopril should be used only after an assessment of benefit and risk, and then with caution. All patients treated with captopril should be told to report any signs of infection (e.g., sore throat, fever). If infection is suspected, perform white cell counts without delay. Since discontinuation of captopril and other drugs has generally led to prompt return of the white count to normal, upon confirmation of neutropenia (neutrophil count $<1000/mm^3$) withdraw captopril and closely follow the patient's course.

Proteinuria: Total urinary proteins >1 g per day were seen in about 0.7% of patients on captopril. About 90% of affected patients had evidence of prior renal disease or received high doses (>150 mg/day), or both. The nephrotic syndrome occurred in about one-fifth of proteinuric patients. In most cases, proteinuria subsided or cleared within 6 months whether or not captopril was continued. The BUN and creatinine were seldom altered in proteinuric patients. Since most cases of proteinuria occurred by the 8th month of therapy with captopril, patients with prior renal disease or those receiving captopril at doses >150 mg per day, should have urinary protein estimates (dip-stick on 1st morning urine) before therapy, and periodically thereafter.

Hypotension: Excessive hypotension was rarely seen in hypertensive patients but is a possibility in severely salt/volume-depleted persons such as those treated vigorously with diuretics (see PRECAUTIONS [Drug Interactions]). In heart failure, where the blood pressure was either normal or low, transient decreases in mean blood pressure >20% were recorded in about half of the patients. This transient hypotension may occur after any of the first several doses and is usually well tolerated, although rarely it has been associated with arrhythmia or conduction defects. A starting dose of 6.25 or 12.5 mg tid may minimize the hypotensive effect. Patients should be followed closely for the first 2 weeks of treatment and whenever the dose of captopril and/or diuretic is increased.

BECAUSE OF THE POTENTIAL FALL IN BLOOD PRESSURE IN THESE PATIENTS, THERAPY SHOULD BE STARTED UNDER VERY CLOSE MEDICAL SUPERVISION.

PRECAUTIONS: General: *Impaired Renal Function* – Hypertension – Some hypertensive patients with renal disease, particularly those with severe renal artery stenosis, have developed increases in BUN and serum creatinine. It may be necessary to reduce captopril dosage and/or discontinue diuretic. For some of these patients, normalization of blood pressure and maintenance of adequate renal perfusion may not be possible. Heart Failure – About 20% of patients develop stable elevations of BUN and serum creatinine >20% above normal or baseline upon long-term treatment. Less than 5% of patients, generally with severe preexisting renal disease, required discontinuation due to progressively increasing creatinine. See DOSAGE AND ADMINISTRATION, ADVERSE REACTIONS [Altered Laboratory Findings]. *Valvular Stenosis* – A theoretical concern, for risk of decreased coronary perfusion, has been noted regarding vasodilator treatment in patients with aortic stenosis due to decreased afterload reduction. *Surgery/Anesthesia* – If hypotension occurs during surgery or anesthesia, and is considered due to the effects of captopril, it is correctable by volume expansion.

Drug Interactions: *Hypotension – Patients on Diuretic Therapy* – Precipitous reduction of blood pressure may occasionally occur within the 1st hour after administration of the initial of captopril dose in patients on diuretics, especially those recently placed on diuretics, and those on severe dietary salt restriction or dialysis. This possibility can be minimized by either discontinuing the diuretic or increasing the salt intake about 1 week prior to initiation of captopril therapy or by initiating therapy with small doses (6.25 or 12.5 mg). Alternatively, provide medical supervision for at least 1 hour after the initial dose.

Agents Having Vasodilator Activity – In heart failure patients, vasodilators should be administered with caution.

Agents Causing Renin Release – Captopril's effect will be augmented by antihypertensive agents that cause renin release.

Agents Affecting Sympathetic Activity – The sympathetic nervous system may be especially important in supporting blood pressure in patients receiving captopril alone or with diuretics. Beta-adrenergic blocking drugs add some further antihypertensive effect to captopril, but the overall response is less than additive. Therefore, use agents affecting sympathetic activity (e.g., ganglionic blocking agents or adrenergic neuron blocking agents) with caution.

Agents Increasing Serum Potassium – Give potassium-sparing diuretics or potassium supplements only for documented hypokalemia, and then with caution, since they may lead to a significant increase of serum potassium. Use potassium-containing salt substitutes with caution.

Inhibitors of Endogenous Prostaglandin Synthesis – Indomethacin and other nonsteroidal anti-inflammatory agents may reduce the antihypertensive effect of captopril, especially in low renin hypertension.

Drug/Laboratory Test Interaction: Captopril may cause a false-positive urine test for acetone.

Carcinogenesis, Mutagenesis and Impairment of Fertility: Two-year studies with doses of 50 to 1350 mg/kg/day in mice and rats failed to show any evidence of carcinogenic potential. Studies in rats have revealed no impairment of fertility.

Pregnancy: Category C: There are no adequate and well-controlled studies in pregnant women. Embryocidal effects and craniofacial malformations were observed in rabbits. Therefore, captopril should be used during pregnancy, or for patients likely to become pregnant, only if the potential benefit outweighs the potential risk to the fetus. Captopril crosses the human placenta.

Nursing Mothers: Captopril is secreted in human milk. Exercise caution when administering captopril to a nursing woman, and, in general, nursing should be interrupted.

Pediatric Use: Safety and effectiveness in children have not been established although there is limited experience with use of captopril in children from 2 months to 15 years of age. Dosage, on a weight basis, was comparable to that used in adults. CAPOTEN (captopril) should be used in children only if other measures for controlling blood pressure have not been effective.

ADVERSE REACTIONS: Reported incidences are based on clinical trials involving approximately 7000 patients.

Renal – About 1 of 100 patients developed proteinuria (see WARNINGS). Renal insufficiency, renal failure, polyuria, oliguria, and urinary frequency in 1 to 2 of 1000 patients.

Hematologic – Neutropenia/agranulocytosis has occurred (see WARNINGS). Anemia, thrombocytopenia, and pancytopenia have been reported.

Dermatologic – Rash, (usually maculopapular, rarely urticarial), often with pruritus, and sometimes with fever and eosinophilia, in about 4 to 7 of 100 patients (depending on renal status and dose), usually during the 1st 4 weeks of therapy. Pruritus, without rash, in about 2 of 100 patients. A reversible associated pemphigoid-like lesion, and photosensitivity, have also been reported. Angioedema of the face, mucous membranes of the mouth, or of the extremities in about 1 of 1000 patients – reversible on discontinuance of captopril therapy. One case of laryngeal edema has been reported. Flushing or pallor in 2 to 5 of 1000 patients.

Cardiovascular – Hypotension may occur; see WARNINGS and PRECAUTIONS [Drug Interactions] for discussion of hypotension on initiation of captopril therapy. Tachycardia, chest pain, and palpitations each in about 1 of 100 patients. Angina pectoris, myocardial infarction, Raynaud's syndrome, and congestive heart failure each in 2 to 3 of 1000 patients.

Dysgeusia – Approximately 2 to 4 (depending on renal status and dose) of 100 patients developed a diminution or loss of taste perception; taste impairment is reversible and usually self-limited even with continued drug use (2 to 3 months). Gastric irritation, abdominal pain, nausea, vomiting, diarrhea, anorexia, constipation, aphthous ulcers, peptic ulcer, dizziness, headache, malaise, fatigue, insomnia, dry mouth, dyspnea, cough, alopecia, paresthesias reported in about 0.5 to 2% of patients but did not appear at increased frequency compared to placebo or other treatments used in controlled trials.

Altered Laboratory Findings: Elevations of liver enzymes in a few patients although no causal relationship has been established. Rarely cholestatic jaundice, and hepatocellular injury with or without secondary cholestasis, have been reported. A transient elevation of BUN and serum creatinine may occur, especially in volume-depleted or renovascular hypertension patients. In instances of rapid reduction of longstanding or severely elevated blood pressure, the glomerular filtration rate may decrease transiently, also resulting in transient rises in serum creatinine and BUN. Small increases in serum potassium concentration frequently occur, especially in patients with renal impairment (see PRECAUTIONS).

OVERDOSAGE: Primary concern is correction of hypotension. Volume expansion with an I.V. infusion of normal saline is the treatment of choice for restoration of blood pressure. Captopril may be removed from the general circulation by hemodialysis.

DOSAGE AND ADMINISTRATION: CAPOTEN (captopril) should be taken one hour before meals. In hypertension, CAPOTEN may be dosed bid or tid. Dosage must be individualized; see DOSAGE AND ADMINISTRATION section of package insert for detailed information regarding dosage in hypertension and in heart failure. Because CAPOTEN (captopril) is excreted primarily by the kidneys, dosage adjustments are recommended for patients with impaired renal function.

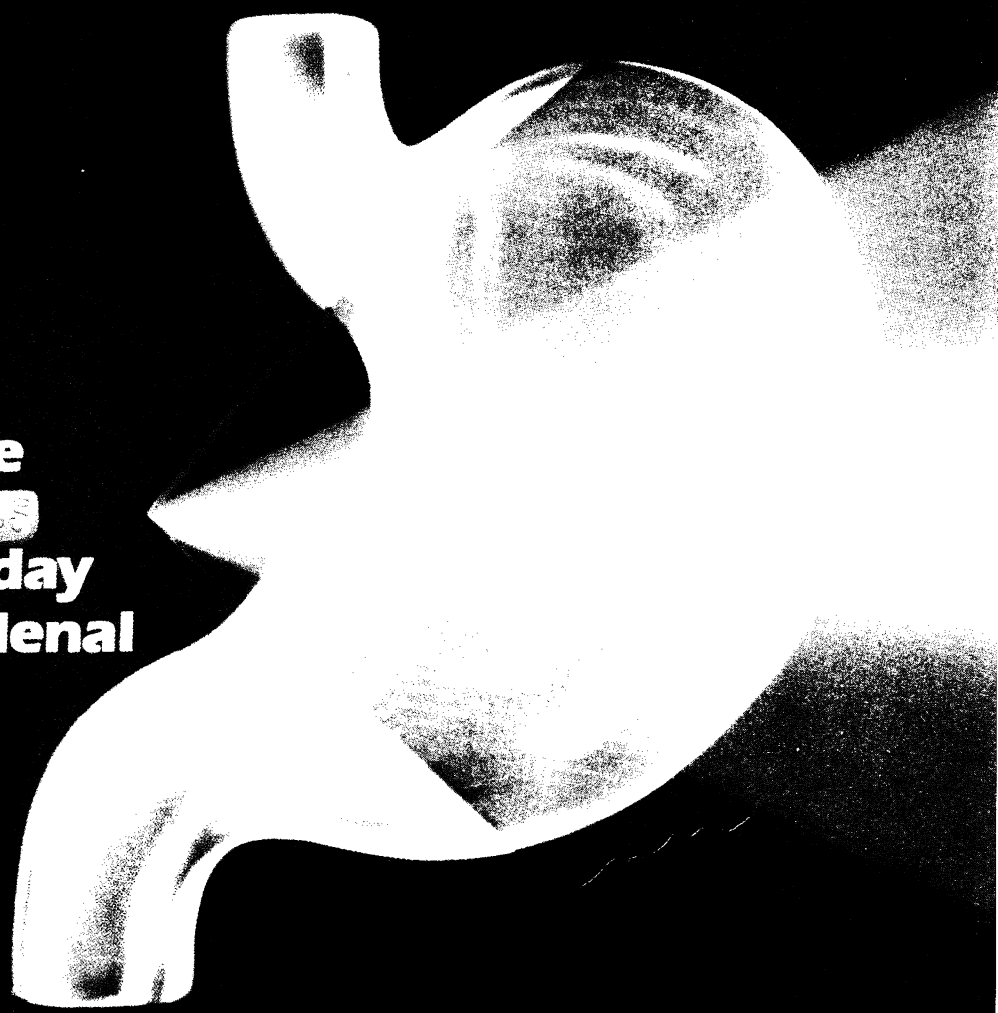
Consult package insert before prescribing CAPOTEN (captopril).

HOW SUPPLIED: Available in tablets of 12.5, 25, 50, and 100 mg in bottles of 100 (25 mg and 50 mg also available in bottles of 1000), and in UNIMATIC® unit-dose packs of 100 tablets. (J3-658J)

SQUIBB

528-509 Issued: January 1988

The One for an Important Spectrum of Patient Benefits



Just one tablet once a day in duodenal ulcer

PEPCID® (Famotidine, MSD) is contraindicated in patients who are hypersensitive to any component of this medication.

Now Available on Medi-Cal May 1, 1988

PROMPT PAIN RELIEF

Begins on day 1, lasts all night and all day in most patients.

RAPID ULCER HEALING

Healing often complete by week 4.

EXCELLENT TOLERABILITY

Generally well tolerated—adverse reaction incidence comparable to placebo in clinical studies.

SIMPLIFIED DOSAGE

One 40-mg tablet h.s. for acute therapy in active duodenal ulcer.

One 20-mg tablet h.s. for maintenance therapy in duodenal ulcer.

Dosing intervals may need to be prolonged or dosage reduced in patients with severe renal insufficiency (creatinine clearance <10 mL/min).

Medi-Cal Approval Numbers	
1758 F	1758 D
40-mg tablet	20-mg tablet

COST-EFFECTIVE THERAPY

Cost per month of therapy less than Zantac.*,**

*registered trademark of Glaxo Group Limited.
**Based on the manufacturer's direct or wholesale price to the retail pharmacist.

TABLETS, 20 mg and 40 mg

Pepcid® ONCE A DAY

(Famotidine/MSD)

MSD
MERCK SHARP & DOHME

For a Brief Summary of Prescribing Information, please see following page.

TABLETS
Pepcid®
(Famotidine/MSD)
20 mg and 40 mg

ORAL SUSPENSION
Pepcid®
(Famotidine for Oral Suspension/MSD)
40 mg per 5 mL

INJECTION
Pepcid® IV
(Famotidine/MSD)
20 mg per 2 mL

Contraindications: Hypersensitivity to any component.

Precautions: ***General:*** Symptomatic response to therapy does not preclude the presence of gastric malignancy.

Patients with Severe Renal Insufficiency: Longer intervals between doses or lower doses may be needed in patients with severe renal insufficiency (creatinine clearance <10 mL/min) to adjust for the longer elimination half-life of famotidine (see Clinical Pharmacology and Dosage and Administration sections of Prescribing Information).

Information for Patients: The oral suspension should be shaken vigorously for 5-10 seconds prior to each use, and unused constituted oral suspension should be discarded after 30 days.

Drug Interactions: No drug interactions have been identified. Compounds tested in man include warfarin, theophylline, phenytoin, diazepam, aminopyrine, and antipyrine.

Carcinogenesis, Mutagenesis, Impairment of Fertility: In rats and mice given oral doses up to approximately 2500 times the recommended human dose for active duodenal ulcer, there was no evidence of carcinogenic potential, no evidence of a mutagenic effect, and fertility and reproductive performance were not affected.

Pregnancy: *Pregnancy Category B*—There are no adequate or well-controlled studies in pregnant women. Use during pregnancy only if clearly needed.

Nursing Mothers: It is not known whether famotidine is secreted into human milk; however, it is secreted into the milk of lactating rats. A decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use: Safety and effectiveness in children have not been established.

Use in Elderly Patients: No dosage adjustment is required based on age but may be necessary in severe renal impairment (see Clinical Pharmacology section of Prescribing Information).

Adverse Reactions: The adverse reactions listed below have been reported during domestic and international clinical trials in approximately 2500 patients. In the placebo-controlled clinical trials, the incidence of adverse experiences with PEPCID Tablets, 40 mg at bedtime, was similar to that with placebo.

Incidence Greater than 1%: The following adverse reactions have been reported to occur in more than 1% of patients on therapy with PEPCID in controlled clinical trials and may be causally related to the drug: headache (4.7%), dizziness (1.3%), constipation (1.2%), and diarrhea (1.7%).

Causal Relationship Unknown: The following other adverse reactions have been reported in clinical trials. While a causal relationship could not be established for these infrequently reported events, causality cannot be excluded. *Body as a Whole*—Fever, asthenia, fatigue. *Cardiovascular*—Palpitations. *Gastrointestinal*—Nausea, vomiting, abdominal discomfort, anorexia, dry mouth, liver enzyme abnormalities. *Hematologic*—Thrombocytopenia. *Hypersensitivity*—Orbital edema, conjunctival injection. *Musculoskeletal*—Musculoskeletal pain, arthralgia. *Nervous System/Psychiatric*—Paresthesias; grand mal seizures (single report); psychic disturbances including depression, anxiety, decreased libido, hallucinations (single report); insomnia; somnolence. *Respiratory*—Bronchospasm. *Skin*—Alopecia, acne, pruritus, rash, dry skin, flushing. *Special Senses*—Tinnitus, taste disorder.

The adverse reactions reported for PEPCID Tablets may also occur with PEPCID Oral Suspension or PEPCID I.V.; in addition, transient irritation at the injection site has been observed with PEPCID I.V.

Management of Overdosage: There is no experience to date with deliberate overdosage. Up to 640 mg/day have been given to patients with pathological hypersecretory conditions with no serious adverse effects. In the event of overdosage, treatment should be symptomatic and supportive. Unabsorbed material should be removed from the gastrointestinal tract, the patient should be monitored, and supportive therapy should be employed.

Dosage and Administration: ***Duodenal Ulcer:*** The recommended adult oral dosage for active duodenal ulcer is 40 mg h.s.; most patients heal within 4 weeks, and it is rarely necessary to use the full dosage for longer than 6 to 8 weeks. A regimen of 20 mg b.i.d. is also effective. For maintenance therapy, the recommended oral dosage is 20 mg h.s.

Pathological Hypersecretory Conditions (e.g., Zollinger-Ellison Syndrome, Multiple Endocrine Adenomas): The dosage varies with the individual patient; the recommended adult oral starting dosage is 20 mg q6h, but some patients may require a higher starting dosage. Dosages should be adjusted to individual patient needs and continued as long as clinically indicated; up to 160 mg q6h have been administered to some patients with severe Zollinger-Ellison syndrome.

Oral Suspension: The Oral Suspension may be substituted for Tablets for those patients who cannot swallow tablets.

Directions for Preparing PEPCID Oral Suspension: Prepare suspension at time of dispensing. Slowly add 46 mL Purified Water. Shake vigorously for 5-10 seconds immediately after adding the water and immediately before use.

Stability of PEPCID Oral Suspension: Unused constituted oral suspension should be discarded after 30 days.

Intravenous Administration: In some hospitalized patients with pathological hypersecretory conditions or intractable ulcers, or in patients who are unable to take oral medication, the recommended intravenous dosage is 20 mg q12h. For preparation of solutions for injection or infusion and for compatible diluents, please see Prescribing Information. Parenteral drug products should be inspected visually for particulate matter and discoloration prior to administration whenever solution and container permit.

Concomitant Use of Antacids: Antacids may be given concomitantly if needed.

Dosage Adjustment for Patients with Severe Renal Insufficiency: In patients with severe renal insufficiency (creatinine clearance less than 10 mL/min), the elimination half-life of famotidine may exceed 20 hours, reaching approximately 24 hours in anuric patients. Although no relationship of adverse effects to high plasma levels has been established, to avoid excess accumulation of the drug, the dosage may be reduced to 20 mg h.s. or the dosing interval may be prolonged to 36 to 48 hours as indicated by the patient's clinical response.

How Supplied: Tablets, containing 20 mg or 40 mg famotidine, with hydroxypropyl cellulose, hydroxypropyl methylcellulose, iron oxides, magnesium stearate, microcrystalline cellulose, starch, talc, and titanium dioxide as inactive ingredients, in bottles of 30 and unit-dose packages of 100; Oral Suspension, containing per 5 mL after constitution with 46 mL Purified Water, 40 mg famotidine, with citric acid, flavors, microcrystalline cellulose and carboxymethylcellulose sodium, sucrose, and xanthan gum as inactive ingredients, and sodium benzoate 0.1%, sodium methylparaben 0.1%, and sodium propylparaben 0.02% added as preservatives, in bottles of 400 mg famotidine for constitution; Solution for intravenous injection, containing 10 mg famotidine per mL, with L-aspartic acid 4 mg, mannitol 20 mg, and water for injection q.s. 1 mL as inactive ingredients, and benzyl alcohol 0.9% added as preservative to the multidose vial, as 10x2-mL single-dose vials and as 4-mL vials.

For more detailed information, consult your MSD Representative or see Prescribing Information.

Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, PA 19486

J8PE26(703)

MSD
MERCK SHARP & DOHME

In the treatment of chronic anxiety...

A benzodiazepine withdrawal syndrome...

It doesn't have to be the price of efficacy.

For Brief Summary, please see last page of this advertisement.

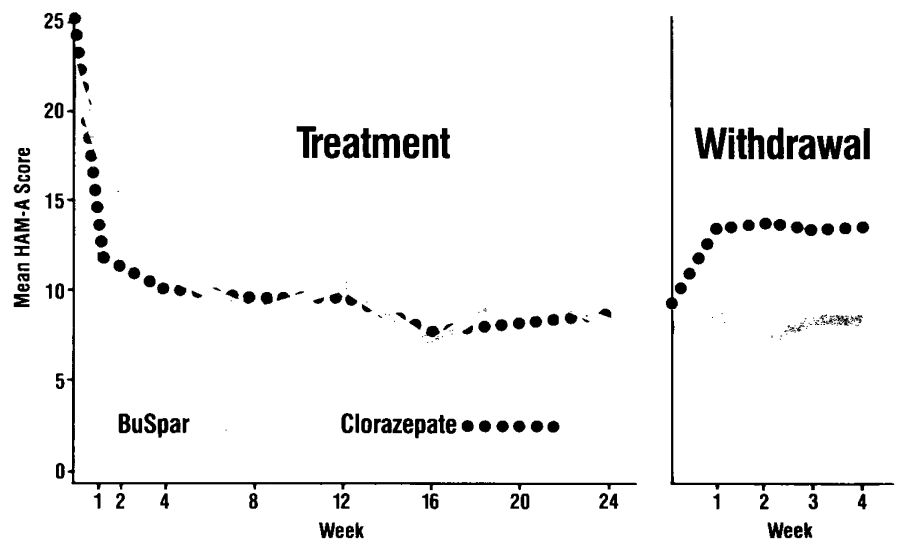
BuSpar® (buspirone HCl)

Tablets, 5 mg and 10 mg

The anxiolytic that breaks the link between efficacy and a withdrawal syndrome

Proven anxiolytic efficacy during treatment... without a withdrawal syndrome when therapy ends[1]

During therapy, BuSpar-treated patients and clorazepate-treated patients experienced significant reductions in Hamilton Anxiety Scale scores. Upon discontinuation of therapy, however, clorazepate-treated patients experienced a significant increase in HAM-A Scale scores, indicating the emergence of a withdrawal syndrome —BuSpar-treated patients did not.



 MJL 7-4221

The first choice for chronic anxiety

BuSpar effectively relieves the symptoms of anxiety—such as irritability, inability to concentrate, and excessive worry or fearfulness—generally without producing euphoria[2] and with no more drowsiness (10%) than induced by placebo (9%).[3]

BuSpar helps restore normal functioning generally without impairing cognition[4] or motor function*[5] or potentiating the effects of alcohol.**[6]

No withdrawal syndrome has been demonstrated in clinical trials with BuSpar, even on abrupt discontinuation of therapy.[1] As a result, you stay in control of the treatment you prescribed.

Counseling and follow-up are important. Patients should be advised that BuSpar does not produce a tranquilizer "buzz," but instead will relieve their symptoms gradually and steadily. Improvement generally is noted within 7 to 10 days. Patients should be monitored for relief of symptoms, improvement in functioning, and an increased capacity to cope.

BuSpar is not a controlled substance. Side effects associated with the use of BuSpar not seen at an equivalent incidence among placebo-treated patients in controlled clinical trials were dizziness (12%), nausea (8%), headache (6%), nervousness (5%), lightheadedness (3%), and excitement (2%).

*Study conducted in normal volunteers. Patients should be cautioned about operating an automobile or using complex machinery until they are reasonably certain that BuSpar treatment does not affect them adversely.

**While formal studies of the interaction of BuSpar with alcohol indicate that it does not increase alcohol-induced impairment in motor and mental performance, it is prudent to avoid concomitant use of alcohol and BuSpar.

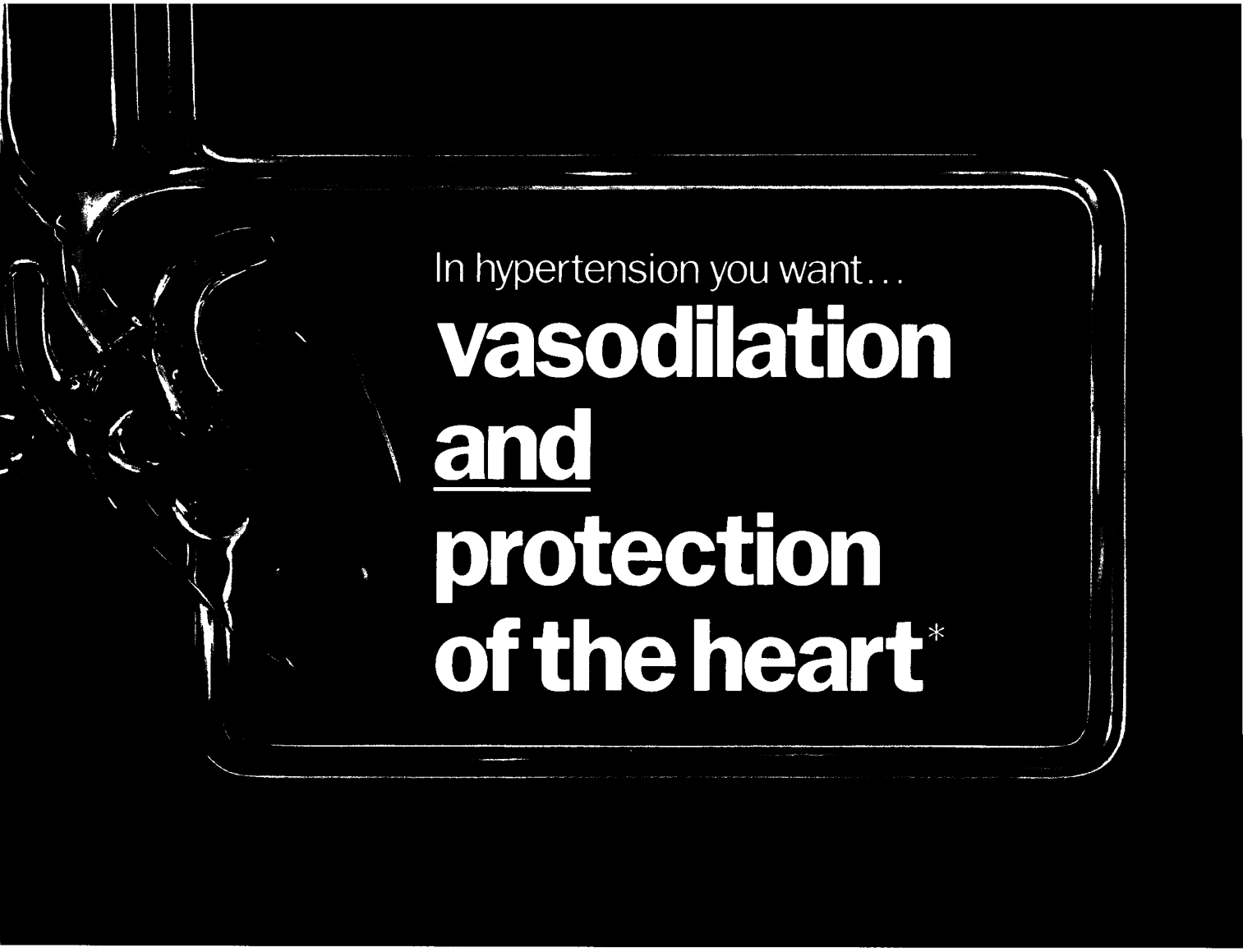
The first choice for chronic anxiety

BuSpar®
Tablets
5 mg and 10 mg

(buspirone HCl)

A different kind of calm

For Brief Summary, please see following page.



NORMODYNE® gives you both
(labetalol HCl) Tablets

	vasodilation	beta blockade
NORMODYNE (labetalol HCl) Tablets	✓	✓
Beta Blockers		✓
ACE Inhibitors	✓	
Calcium Channel Blockers	✓	

- ☐ Low incidence of impotence, fatigue, or cold extremities†
- ☐ Lipid and potassium levels are not adversely affected
- ☐ Minimizes risk of reflex tachycardia
- ☐ Maintains cardiac output
- ☐ Maintains exercise capacity
- ☐ Does not adversely affect heart rate
- ☐ Maintains blood flow to vital organs
- ☐ Renal function is unimpaired

*reduces double product (HR × SBP) and minimizes the risk of reflex tachycardia

†Most adverse effects are mild, transient, and occur early in the course of treatment. In controlled clinical trials of three to four months' duration, the most common side effects noted in treating mild to moderate hypertension with NORMODYNE (labetalol HCl) Tablets include dizziness (11%), nausea (6%), and fatigue (5%). Dyspepsia (3%), nasal stuffiness (3%), impotence (1%), and drowsiness (<1%) occurred to a lesser degree. Overall, reports of symptomatic postural hypotension have been uncommon and have included rare instances of syncope. For complete side effects profile, see Prescribing Information.

For Brief Summary, please see reverse side of page.

KEY™ Key Pharmaceuticals, Inc.
Kenilworth, NJ 07033
World leader in drug delivery systems.

13071942-JBS **PRODUCT INFORMATION**

NORMODYNE®

brand of labetalol hydrochloride

Tablets

BRIEF SUMMARY

INDICATIONS AND USAGE

NORMODYNE (labetalol HCl) Tablets are indicated in the management of hypertension. NORMODYNE Tablets may be used alone or in combination with other antihypertensive agents, especially thiazide and loop diuretics.

CONTRAINDICATIONS

NORMODYNE (labetalol HCl) Tablets are contraindicated in bronchial asthma, overt cardiac failure, greater than first degree heart block, cardiogenic shock, and severe bradycardia (see WARNINGS).

WARNINGS

Cardiac Failure Sympathetic stimulation is a vital component supporting circulatory function in congestive heart failure. Beta blockade carries a potential hazard of further depressing myocardial contractility and precipitating more severe failure. Although beta-blockers should be avoided in overt congestive heart failure, if necessary, labetalol HCl can be used with caution in patients with a history of heart failure who are well-compensated. Congestive heart failure has been observed in patients receiving labetalol HCl. Labetalol HCl does not abolish the inotropic action of digitalis on heart muscle.

In Patients Without a History of Cardiac Failure In patients with latent cardiac insufficiency, continued depression of the myocardium with beta-blocking agents over a period of time can, in some cases, lead to cardiac failure. At the first sign or symptom of impending cardiac failure, patients should be fully digitalized and/or be given a diuretic, and the response observed closely. If cardiac failure continues, despite adequate digitalization and diuretic, NORMODYNE (labetalol HCl) therapy should be withdrawn (gradually if possible).

Exacerbation of Ischemic Heart Disease Following Abrupt Withdrawal Angina pectoris has not been reported upon labetalol HCl discontinuation. However, hypersensitivity to catecholamines has been observed in patients withdrawn from beta-blocker therapy; exacerbation of angina and, in some cases, myocardial infarction have occurred after *abrupt* discontinuation of such therapy. When discontinuing chronically administered NORMODYNE (labetalol HCl), particularly in patients with ischemic heart disease, the dosage should be gradually reduced over a period of one to two weeks and the patient should be carefully monitored. If angina markedly worsens or acute coronary insufficiency develops, NORMODYNE (labetalol HCl) administration should be reinstituted promptly, at least temporarily, and other measures appropriate for the management of unstable angina should be taken. Patients should be warned against interruption or discontinuation of therapy without the physician's advice. Because coronary artery disease is common and may be unrecognized, it may be prudent not to discontinue NORMODYNE (labetalol HCl) therapy abruptly even in patients treated only for hypertension.

Nonallergic Bronchospasm (e.g., chronic bronchitis and emphysema) Patients with bronchospastic disease should, in general, not receive beta-blockers. NORMODYNE may be used with caution, however, in patients who do not respond to, or cannot tolerate, other antihypertensive agents. It is prudent, if NORMODYNE is used, to use the smallest effective dose, so that inhibition of endogenous or exogenous beta-agonists is minimized.

Pheochromocytoma Labetalol HCl has been shown to be effective in lowering the blood pressure and relieving symptoms in patients with pheochromocytoma. However, paradoxical hypertensive responses have been reported in a few patients with this tumor; therefore, use caution when administering labetalol HCl to patients with pheochromocytoma.

Diabetes Mellitus and Hypoglycemia Beta-adrenergic blockade may prevent the appearance of premonitory signs and symptoms (e.g., tachycardia) of acute hypoglycemia. This is especially important with labile diabetics. Beta-blockade also reduces the release of insulin in response to hyperglycemia; it may therefore be necessary to adjust the dose of antidiabetic drugs.

Major Surgery The necessity or desirability of withdrawing beta-blocking therapy prior to major surgery is controversial. Protracted severe hypotension and difficulty in restarting or maintaining a heart beat have been reported with beta-blockers. The effect of labetalol HCl's alpha-adrenergic activity has not been evaluated in this setting.

A synergism between labetalol HCl and halothane anesthesia has been shown (see Drug Interactions).

PRECAUTIONS

General *Impaired Hepatic Function* NORMODYNE (labetalol HCl) Tablets should be used with caution in patients with impaired hepatic function since metabolism of the drug may be diminished.

Jaundice or Hepatic Dysfunction On rare occasions, labetalol HCl has been associated with jaundice (both hepatic and cholestatic). It is therefore recommended that treatment with labetalol HCl be stopped immediately should a patient develop jaundice or laboratory evidence of liver injury. Both have been shown to be reversible on stopping therapy.

Information for Patients

As with all drugs with beta-blocking activity, certain advice to patients being treated with labetalol HCl is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects. While no incident of the abrupt withdrawal phenomenon (exacerbation of angina pectoris) has been reported with labetalol HCl, dosing with NORMODYNE Tablets should not be interrupted or discontinued without a physician's advice. Patients being treated with NORMODYNE Tablets should consult a physician at any sign of impending cardiac failure. Also, transient scalp tingling may occur, usually when treatment with NORMODYNE Tablets is initiated (see ADVERSE REACTIONS).

Laboratory Tests

As with any new drug given over prolonged periods, laboratory parameters should be observed over regular intervals. In patients with concomitant illnesses, such as impaired renal function, appropriate tests should be done to monitor these conditions.

Drug Interactions

In one survey, 2.3% of patients taking labetalol HCl in combination with tricyclic antidepressants experienced tremor as compared to 0.7% reported to occur with labetalol HCl alone. The contribution of each of the treatments to this adverse reaction is unknown but the possibility of a drug interaction cannot be excluded.

Drugs possessing beta-blocking properties can blunt the bronchodilator effect of beta-receptor agonist drugs in patients with bronchospasm; therefore, doses greater than the normal anti-asthmatic dose of beta-agonist bronchodilator drugs may be required.

Cimetidine has been shown to increase the bioavailability of labetalol HCl. Since this could be explained either by enhanced absorption or by an alteration of hepatic metabolism of labetalol HCl, special care should be used in establishing the dose required for blood pressure control in such patients.

Synergism has been shown between halothane anesthesia and intravenously administered labetalol HCl. During controlled hypotensive anesthesia using labetalol HCl in association with halothane, high concentrations (3% or above) of halothane should not be used because the degree of hypotension will be increased and because of the possibility of a large reduction in cardiac output and an increase in central venous pressure. The anesthesiologist should be informed when a patient is receiving labetalol HCl.

Labetalol HCl blunts the reflex tachycardia produced by nitroglycerin without preventing its hypotensive effect. If labetalol HCl is used with nitroglycerin in patients with angina pectoris, additional antihypertensive effects may occur.

Drug/Laboratory Test Interactions

The presence of a metabolite of labetalol in the urine may result in falsely increased levels of urinary catecholamines when measured by a nonspecific trihydroxyindole (THI) reaction. In screening patients suspected of having a pheochromocytoma and being treated with labetalol HCl, specific radioenzymatic or high performance liquid chromatography assay techniques should be used to determine levels of catecholamines or their metabolites.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Long-term oral dosing studies with labetalol HCl for 18 months in mice and for 2 years in rats showed no evidence of carcinogenesis. Studies with labetalol HCl, using dominant lethal assays in rats and mice, and exposing microorganisms according to modified Ames tests, showed no evidence of mutagenesis.

Pregnancy Category C

Teratogenic studies have been performed with labetalol in rats and rabbits at oral doses up to approximately 6 and 4 times the maximum recommended human dose (MRHD), respectively. No reproducible evidence of fetal malformations was observed. Increased fetal resorptions were seen in both species at doses approximating the MRHD. There are no adequate and well-controlled studies in pregnant women. Labetalol should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nonteratogenic Effects

Infants of mothers who were treated with labetalol HCl for hypertension during pregnancy did not appear to be adversely affected by the drug. Oral administration of labetalol to rats during late gestation through weaning at doses of 2 to 4 times the MRHD caused a decrease in neonatal survival.

Labor and Delivery

Labetalol HCl given to pregnant women with hypertension did not appear to affect the usual course of labor and delivery.

Nursing Mothers

Small amounts of labetalol (approximately 0.004% of the maternal dose) are excreted in human milk. Caution should be exercised when NORMODYNE Tablets are administered to a nursing woman.

Pediatric Use

Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Most adverse effects are mild, transient and occur early in the course of treatment. In controlled clinical trials of 3 to 4 months duration, discontinuation of NORMODYNE (labetalol HCl) Tablets due to one or more adverse effects was required in 7% of all patients. In these same trials, beta-blocker control agents led to discontinuation in 8 to 10% of patients, and a centrally acting alpha-agonist in 30% of patients.

The incidence rates of adverse reactions listed in the following table were derived from multicenter controlled clinical trials, comparing labetalol HCl, placebo, metoprolol and propranolol, over treatment periods of 3 and 4 months. Where the frequency of adverse effects for labetalol HCl and placebo is similar, causal relationship is uncertain. The rates are based on adverse reactions considered probably drug-related by the investigator. If all reports are considered, the rates are somewhat higher (e.g., dizziness 20%, nausea 14%, fatigue 11%), but the overall conclusions are unchanged.

	Labetalol HCl (N = 227) %	Placebo (N = 98) %	Propranolol (N = 84) %	Metoprolol (N = 49) %
Body as a whole				
fatigue	5	0	12	12
asthenia	1	1	1	0
headache	2	1	1	2
Gastrointestinal				
nausea	6	1	1	2
vomiting	<1	0	0	0
dyspepsia	3	1	1	0
abdominal pain	0	0	1	2
diarrhea	<1	0	2	0
taste distortion	1	0	0	0
Central and Peripheral Nervous Systems				
dizziness	11	3	4	4
paresthesias	<1	0	0	0
drowsiness	<1	2	2	2
Autonomic Nervous System				
nasal stuffiness	3	0	0	0
ejaculation failure	2	0	0	0
impotence	1	0	1	3
increased sweating	<1	0	0	0
Cardiovascular				
edema	1	0	0	0
postural hypotension	1	0	0	0
bradycardia	0	0	5	12
Respiratory				
dyspnea	2	0	1	2
Skin				
rash	1	0	0	0
Special Senses				
vision abnormality	1	0	0	0
vertigo	2	1	0	0

The adverse effects were reported spontaneously and are representative of the incidence of adverse effects that may be observed in a properly selected hypertensive patient population, i.e., a group excluding patients with bronchospastic disease, overt congestive heart failure, or other contraindications to beta-blocker therapy.

Clinical trials also included studies utilizing daily doses up to 2400 mg in more severely hypertensive patients. Certain of the side effects increased with increasing dose as shown in the table below which depicts the entire U.S. therapeutic trials data base for adverse reactions that are clearly or possibly dose related.

Labetalol HCl Daily Dose (mg)	200	300	400	600
Number of Patients	522	181	606	608
Dizziness (%)	2	3	3	3
Fatigue	2	1	4	4
Nausea	<1	0	1	2
Vomiting	0	0	<1	<1
Dyspepsia	1	0	2	1
Paresthesias	2	0	2	2
Nasal Stuffiness	1	1	2	2
Ejaculation Failure	0	2	1	2
Impotence	1	1	1	1
Edema	1	0	1	1

Labetalol HCl Daily Dose (mg)	800	900	1200	1600	2400
Number of Patients	503	117	411	242	175
Dizziness (%)	5	1	9	13	16
Fatigue	5	3	7	6	10
Nausea	4	0	7	11	19
Vomiting	<1	0	1	2	3
Dyspepsia	1	0	2	2	4

Labetalol HCl Daily Dose (mg) (cont.)	800	900	1200	1600	2400
Paresthesias	1	1	2	5	5
Nasal Stuffiness	2	2	4	5	6
Ejaculation Failure	3	0	4	3	5
Impotence	2	4	3	4	3
Edema	1	0	1	2	2

In addition, a number of other less common adverse events have been reported in clinical trials or the literature:

Cardiovascular Postural hypotension, including rarely, syncope.

Central and Peripheral Nervous Systems Paresthesias, most frequently described as scalp tingling. In most cases, it was mild, transient and usually occurred at the beginning of treatment.

Collagen Disorders Systemic lupus erythematosus; positive antinuclear factor (ANF).

Eyes Dry eyes.

Immunological System Antimitochondrial antibodies.

Liver and Biliary System Cholestasis with or without jaundice.

Musculo-Skeletal System Muscle cramps; toxic myopathy.

Respiratory System Bronchospasm.

Skin and Appendages Rashes of various types, such as generalized maculo-papular; lichenoid; urticarial; bullous lichen planus; psoriaform; facial erythema; Peyronie's disease; reversible alopecia.

Urinary System Difficulty in micturition, including acute urinary bladder retention.

Following approval for marketing in the United Kingdom, a monitored release survey involving approximately 6,800 patients was conducted for further safety and efficacy evaluation of this product. Results of this survey indicate that the type, severity, and incidence of adverse effects were comparable to those cited above.

Potential Adverse Effects

In addition, other adverse effects not listed above have been reported with other beta-adrenergic blocking agents.

Central Nervous System Reversible mental depression progressing to catatonia; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Cardiovascular Intensification of AV block. See CONTRAINDICATIONS.

Allergic Fever combined with aching and sore throat; laryngospasm; respiratory distress.

Hematologic Agranulocytosis; thrombocytopenic or nonthrombocytopenic purpura.

Gastrointestinal Mesenteric artery thrombosis; ischemic colitis.

The oculomucocutaneous syndrome associated with the beta-blocker practolol has not been reported with labetalol HCl.

Clinical laboratory tests: There have been reversible increases of serum transaminases in 4% of patients treated with labetalol HCl and tested, and more rarely, reversible increases in blood urea.

OVERDOSAGE

Overdosage with NORMODYNE (labetalol HCl) Tablets causes excessive hypotension which is posture sensitive, and sometimes, excessive bradycardia. Patients should be laid supine and their legs raised if necessary to improve the blood supply to the brain. The following additional measures should be employed if necessary: *Excessive bradycardia* — administer atropine (3.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously. *Cardiac failure* — administer a digitalis glycoside and a diuretic. *Hypotension* — administer vasopressors, e.g., norepinephrine. There is pharmacological evidence that norepinephrine may be the drug of choice. *Bronchospasm* — administer a beta$_2$-stimulating agent and/or a theophylline preparation.

Gastric lavage or pharmacologically induced emesis (using syrup of ipecac) is useful for removal of the drug shortly after ingestion. Labetalol HCl can be removed from the general circulation by hemodialysis.

The oral LD_{50} value of labetalol HCl in the mouse is approximately 600 mg/kg and in the rat is greater than 2 gm/kg. The intravenous LD_{50} in these species is 50 to 60 mg/kg.

DOSAGE AND ADMINISTRATION

DOSAGE MUST BE INDIVIDUALIZED. The recommended initial dose is 100 mg twice daily whether used alone or added to a diuretic regimen. After 2 or 3 days, using standing blood pressure as an indicator, dosage may be titrated in increments of 100 mg bid every 2 or 3 days. The usual maintenance dosage of labetalol HCl is between 200 and 400 mg twice daily.

Since the full antihypertensive effect of labetalol HCl is usually seen within the first one to three hours of the initial dose or dose increment, the assurance of a lack of an exaggerated hypotensive response can be clinically established in the office setting. The antihypertensive effects of continued dosing can be measured at subsequent visits, approximately 12 hours after a dose, to determine whether further titration is necessary.

Patients with severe hypertension may require from 1200 mg to 2400 mg per day, with or without thiazide diuretics. Should side effects (principally nausea or dizziness) occur with these doses administered bid, the same total daily dose administered three times daily may improve tolerability and facilitate further titration. Titration increments should not exceed 200 mg twice daily.

When a diuretic is added, an additive antihypertensive effect can be expected. In some cases this may necessitate a labetalol HCl dosage adjustment. As with most antihypertensive drugs, optimal dosages of NORMODYNE Tablets are usually lower in patients also receiving a diuretic.

When transferring patients from other antihypertensive drugs, NORMODYNE Tablets should be introduced as recommended and the dosage of the existing therapy progressively decreased.

HOW SUPPLIED

NORMODYNE (labetalol HCl) Tablets, 100 mg, light-brown, round, scored, film-coated tablets engraved on one side with Schering and product identification numbers 244, and on the other side the number 100 for the strength and "NORMODYNE"; bottles of 100 (NDC-0085-0244-04), 500 (NDC-0085-0244-05), and box of 100 for unit-dose dispensing (NDC-0085-0244-08).

NORMODYNE (labetalol HCl) Tablets, 200 mg, white, round, scored, film-coated tablets engraved on one side with Schering and product identification numbers 752, and on the other side the number 200 for the strength and "NORMODYNE"; bottles of 100 (NDC-0085-0752-04), 500 (NDC-0085-0752-05), box of 100 for unit-dose dispensing (NDC-0085-0752-08), and Patient Calendar Package of 56 (4 bottles of 14 tablets) (NDC-0085-0752-03).

NORMODYNE (labetalol HCl) Tablets, 300 mg, blue, round, film-coated tablets engraved on one side with Schering and product identification numbers 438, and on the other side the number 300 for the strength and "NORMODYNE"; bottles of 100 (NDC-0085-0438-03), 500 (NDC-0085-0438-05), box of 100 for unit-dose dispensing (NDC-0085-0438-06), and Patient Calendar Package of 56 (4 bottles of 14 tablets) (NDC-0085-0438-02).

NORMODYNE (labetalol HCl) Tablets should be stored between 2° and 30°C (36° and 86°F).

NORMODYNE (labetalol HCl) Tablets in the unit-dose boxes should be protected from excessive moisture.

For complete prescribing information, please consult package insert.

Key Pharmaceuticals, Inc.
Kenilworth, NJ 07033 USA

Revised 3/85

NR-613/14315403

Soon more than a million.

Soon more than a million insulin users will be taking Humulin.

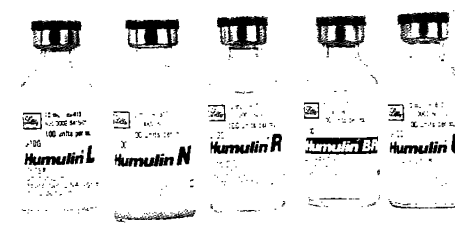
And no wonder. Humulin is identical to the insulin produced by the human pancreas—except that it is made by rDNA technology.

Humulin is not derived from animal pancreases. So it contains none of the animal-source pancreatic impurities that may contribute to insulin allergies or immunogenicity.

The clinical significance of insulin antibodies in the complications of diabetes is uncertain at this time. However, high antibody titers have been shown to decrease the small amounts of endogenous insulin secretion some insulin users still have. The lower immunogenicity of Humulin has been shown to result in lower insulin antibody titers; thus, Humulin may help to prolong endogenous insulin production in some patients.

Any change of insulin should be made cautiously and only under medical supervision. Changes in refinement, purity, strength, brand (manufacturer), type (regular, NPH, Lente®, etc), species/source (beef, pork, beef-pork, or human), and/or method of manufacture (recombinant DNA versus animal-source insulin) may result in the need for a change in dosage.

DIET...EXERCISE...



Humulin®
human insulin
(recombinant DNA origin)

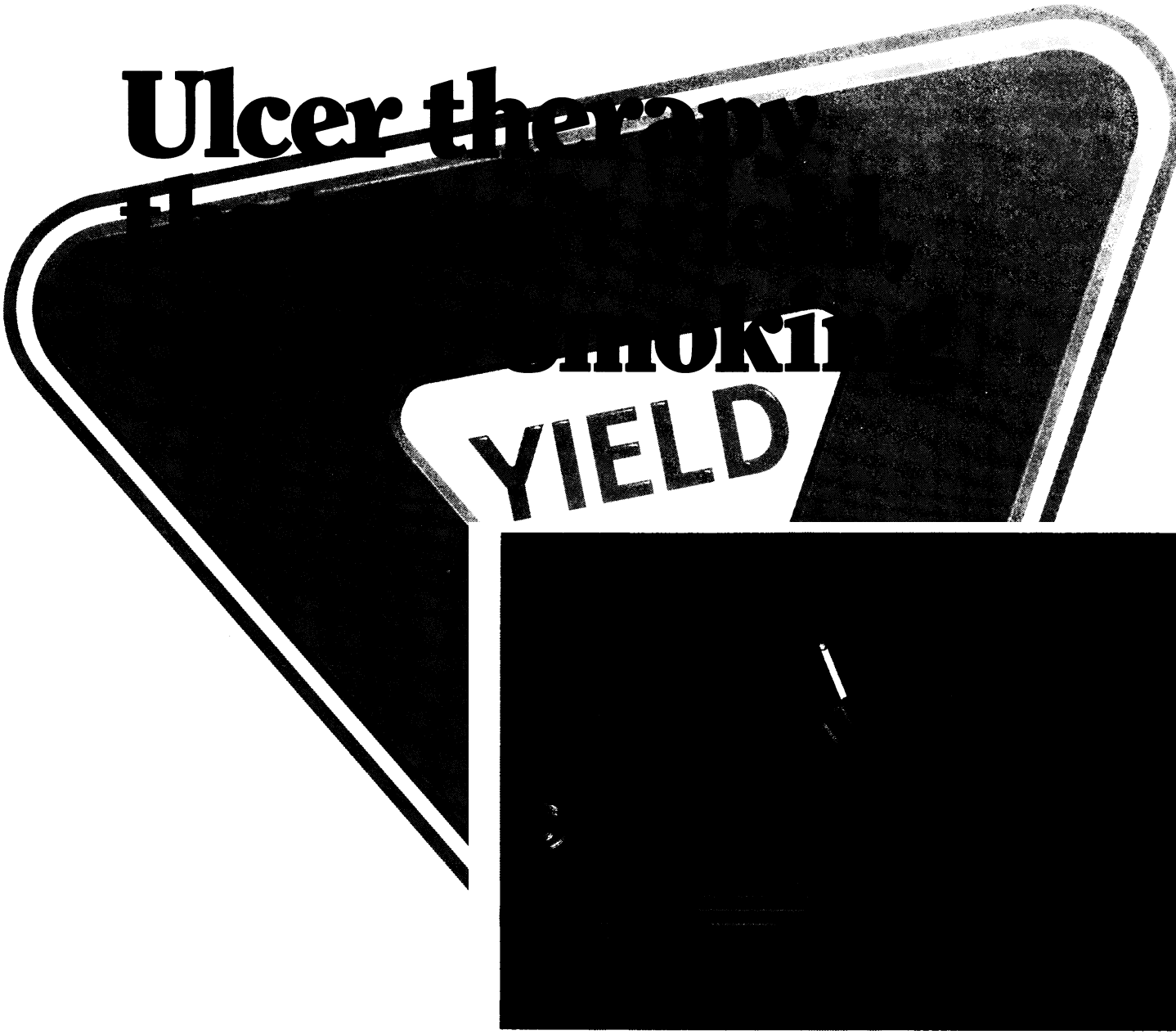
For your insulin-using patients

Lilly Leadership IN DIABETES CARE

Lilly

Eli Lilly and Company
Indianapolis, Indiana
46285

Ulcer therapy that won't go up in smoke



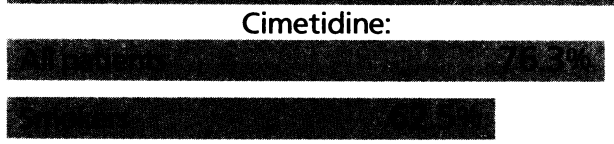
What do you do for duodenal ulcer patients who should stop smoking, but won't? Both cimetidine[1] and ranitidine[2] have been shown less effective in smokers than nonsmokers.

Choose CARAFATE® (sucralfate/Marion). Two recent studies show Carafate to be as effective in smokers as nonsmokers.[3,4] A difference further illustrated in a 283-patient study comparing sucralfate to cimetidine[5]:

Ulcer healing rates:
(at four weeks of therapy)[5]

Sucralfate:

Cimetidine:



*Significantly greater than cimetidine smoker group ($P<.05$).

...a unique, nonsystemic mode of action ...the body's own ulcer healing ability and protect... damaged mucosa from further injury. ...When your ulcer patient is a smoker, prescribe the ulcer medication that won't go up in smoke: safe, nonsystemic Carafate.

Nothing works like

CARAFATE®
sucralfate/Marion

Please see adjoining page for references and brief summary of prescribing information.

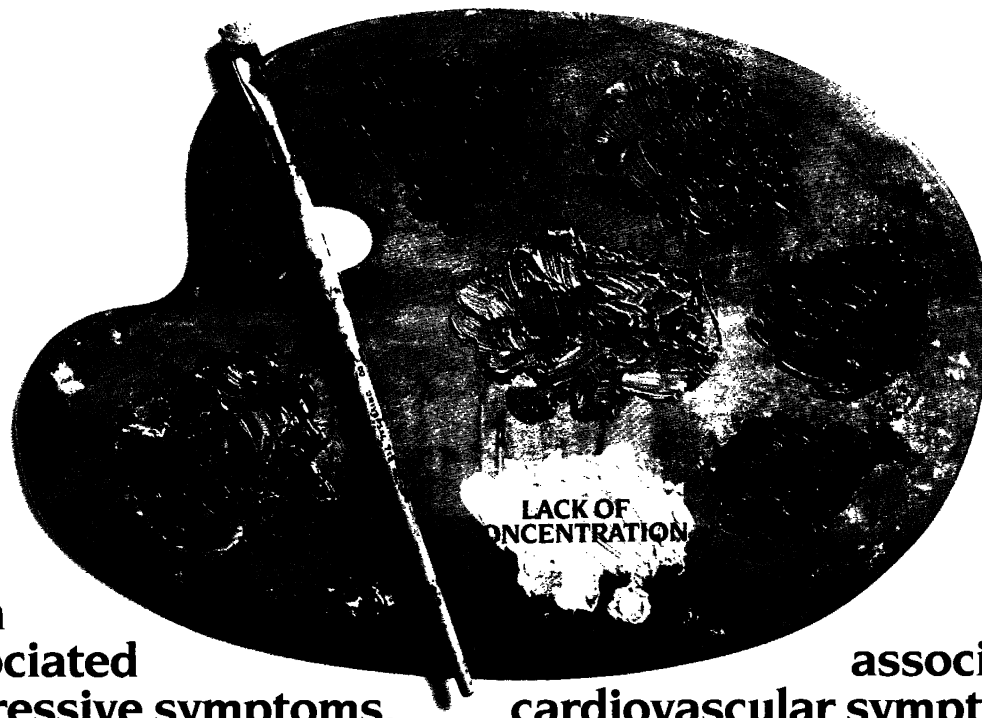
0825A8

The portrait of anxiety

Upjohn The Upjohn Company
Kalamazoo Michigan 49001 USA

Please see adjacent page for brief summary of prescribing information.

is often complicated

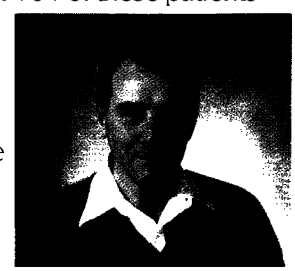


With associated depressive symptoms.

In double-blind, four-week clinical trials in 632 patients with moderate to severe anxiety, therapy with XANAX was compared with placebo.

XANAX was significantly more effective ($P<.001$) than placebo in relieving the anxiety, with over half of the patients showing marked to moderate improvement by the first evaluation period (one week).

In addition, over 70% of these patients experienced associated moderate to severe depressed mood. XANAX was shown to be significantly more effective ($P<.014$) than placebo in improving the associated depressed mood.



With associated cardiovascular symptoms.

Almost 60% of patients in the study had anxiety with associated cardiovascular symptoms even though cardiovascular disease had been ruled out. XANAX was shown to effectively relieve anxiety including the associated cardiovascular symptoms.

XANAX, the first of a unique class—the triazolobenzodiazepines.

- *Well tolerated*—Side effects, if they occur, are generally observed at the beginning of therapy and usually disappear with continued medication. Drowsiness and light-headedness were the most commonly reported adverse reactions.
- *Sustained efficacy*—No reported increase in dosage during 16-week clinical study, once an appropriate dosage was achieved. Since long-term effectiveness of XANAX has not been established, it is recommended that it not be used for longer than 16 weeks.
- *Simple dosage*—0.25 to 0.5 mg t.i.d.

TABLETS 0.25, 0.5 & 1 MG

Xanax®

alprazolam IV

for the relief of complicated anxiety

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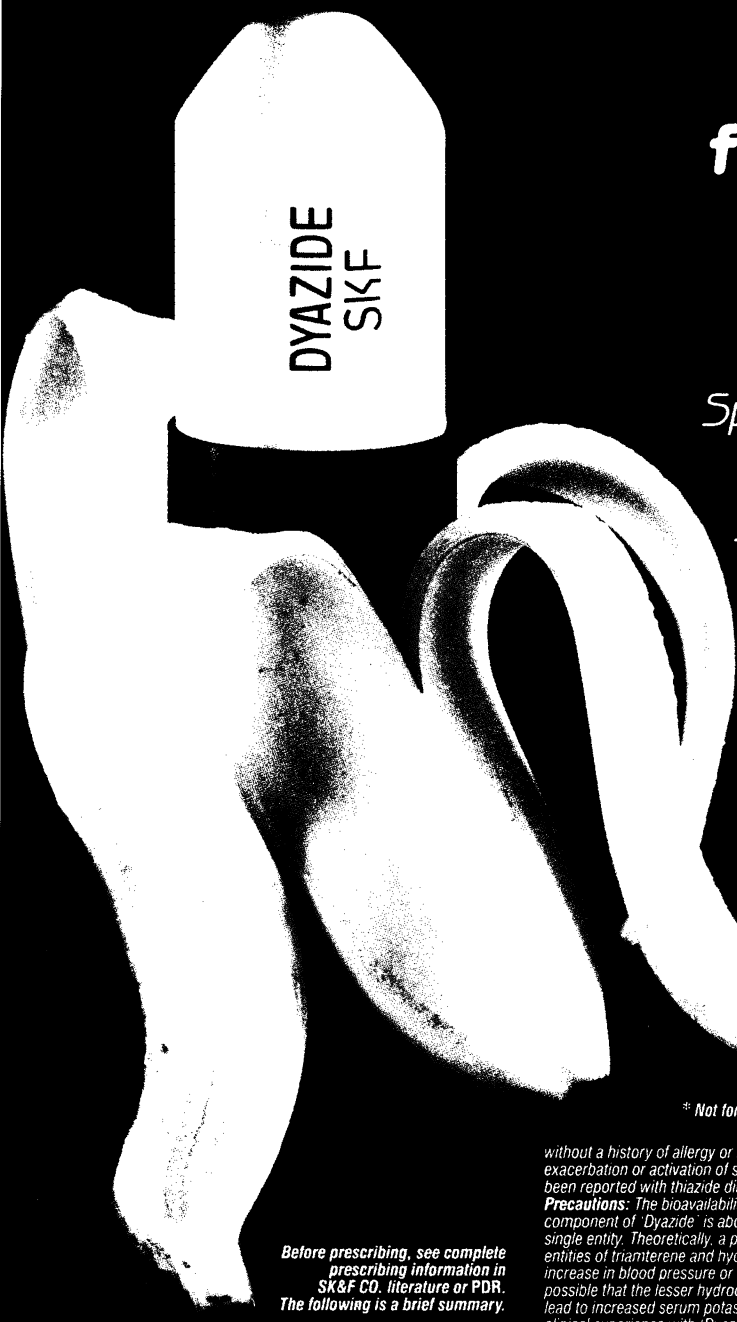
A better alternative for hypertensives who are going bananas...



Spare your patients the extra cost—in calories, sodium and dollars.

Spare your patients the rigors of dietary K^+ supplementation.

®

***25 mg** Hydrochlorothiazide/**50 mg** Triamterene/SK&F*

Effective antihypertensive* therapy...without the bananas

DAW
'DYAZIDE' AS WRITTEN.

* Not for initial therapy. See brief summary.

***Before prescribing, see complete prescribing information in SK&F CO. literature or* PDR.**
The following is a brief summary.

* ***WARNING***

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: *Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.*

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. *If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake.* ***Associated widened QRS complex or arrhythmia requires prompt additional therapy.*** *Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.*

Precautions: *The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of triamterene and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Angiotensin-converting enzyme (ACE) inhibitors can elevate serum potassium; use with caution with 'Dyazide'. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin[ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function. Thiazides may add to or potentiate the action of other antihypertensive drugs. Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.*

Adverse Reactions: *Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances, postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.*

Supplied: ***'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.***

BRS-DZ:L45

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Cidra, P.R. 00639

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Catapres-TTS®–2 I.D. #3303G
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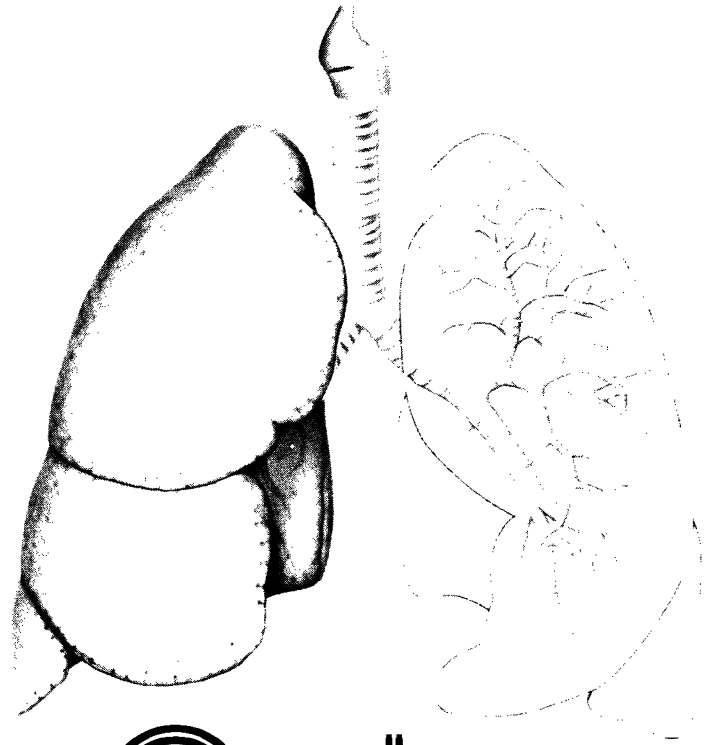
Medicine They Wear

Catapres-TTS®

Consider the causative organisms...



Ceclor® cefaclor

250-mg Pulvules® t.i.d. offers effectiveness against the major causes of bacterial bronchitis

Haemophilus influenzae and *Streptococcus pneumoniae*
(ampicillin-susceptible and ampicillin-resistant)

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

Ceclor® (cefaclor)

Summary. Consult the package literature for prescribing information.

Indications: Lower respiratory infections, including pneumonia, caused by *Streptococcus pneumoniae, Haemophilus influenzae,* and *Streptococcus pyogenes* (group A β-hemolytic streptococci).

Contraindication:
Known allergy to cephalosporins.

Warnings:
CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:
- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:
- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever): 1.5%; usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%; and, rarely, thrombocytopenia.

Abnormalities in laboratory results of uncertain etiology.
- Slight elevations in hepatic enzymes.
- Transient fluctuations in leukocyte count (especially in infants and children).
- Abnormal urinalysis; elevations in BUN or serum creatinine.
- Positive direct Coombs' test.
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest® tablets but not with Tes-Tape® (glucose enzymatic test strip, Lilly). [061787L]

PA 0709 AMP

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.

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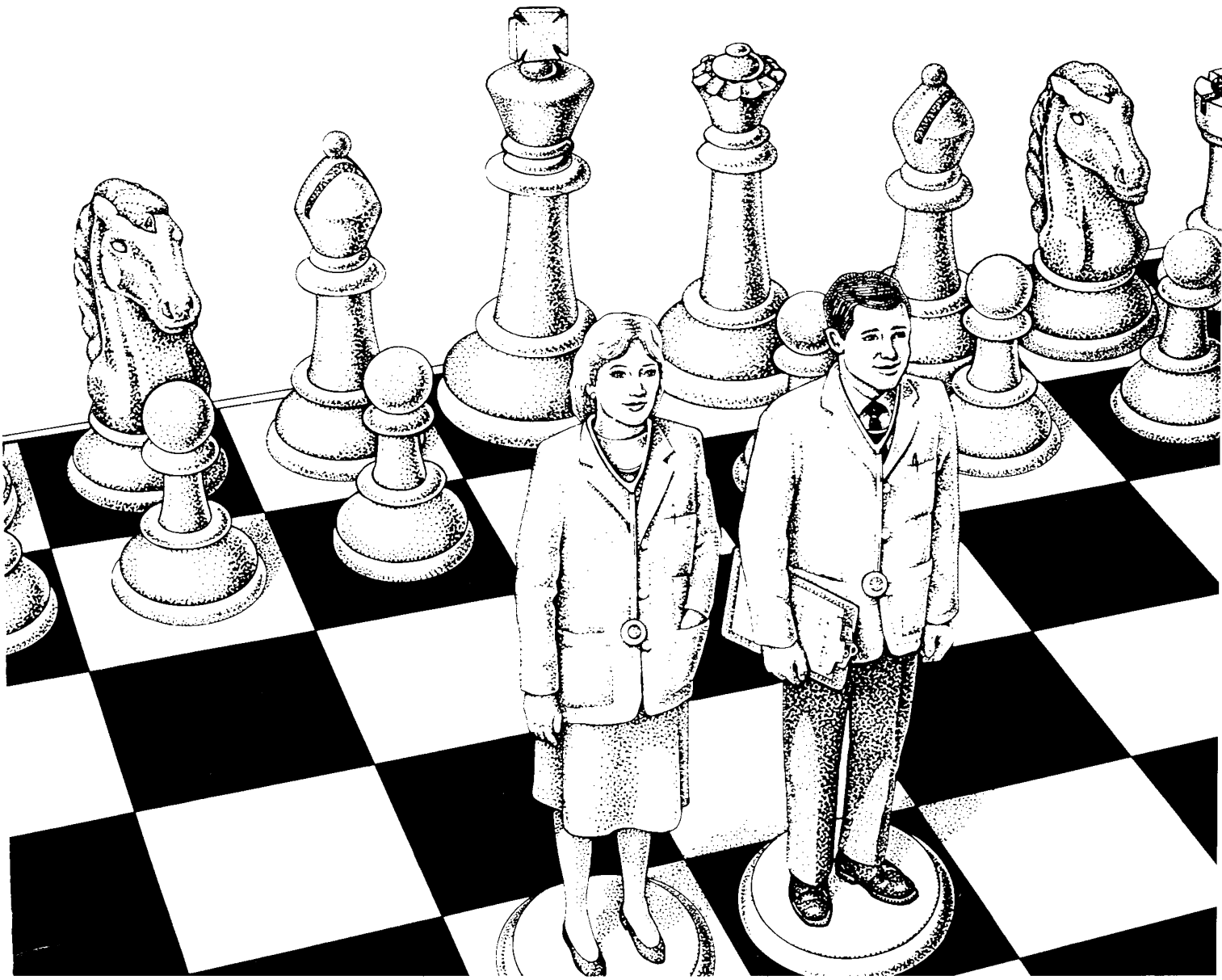

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PHYSICIANS WANTED

EMERGENCY MEDICINE. We are an established 35 physician partnership in northern California and we are seeking BE/BC Emergency Physicians to join us. All of our facilities have moderate volumes, many serve as EMS base-stations. Salary and benefits are competitive; malpractice is paid. If interested in a career in Emergency Medicine with us, please contact Sacramento Emergency Medical Group, 4325 Auburn Blvd, Ste 100, Sacramento, CA 95841; (916) 486-4414.

FAMILY PRACTITIONER. Visalia Medical Clinic has an opening for a BC/BE Family Practitioner to join a four physician department. Located in the San Joaquin Valley of California, serving a market area of approximately 350,000 citizens, the Visalia Medical Clinic is a 40 physician multispecialty clinic. Excellent hospital services and facilities. Compensation is incentive oriented with advancement to full partnership after one year. Excellent fringe benefits. John G. Heinsohn, Administrator, 5400 W. Hillsdale, Visalia, CA 93291; (209) 733-5222.

NEAR STANFORD. Six Internists, all subspecialty trained and members of clinical faculty at Stanford, interested in an Associate with subspecialty interest and training. Should be well grounded in Internal Medicine. Send CV to Dr Bigler, El Camino Internal Medical Group, 125 South Dr, Mountain View, CA 94040.

CRESCENT CITY, CALIFORNIA. Exciting position available at a growing 24,000 visit ER in a rural, coastal community. Fee-for-service with possibility of six figure income. Send CV to Art B. Wong, MD, FACEP, 1 Maritime Plaza, Ste 710, San Francisco, CA 94111.

NEUROSURGERY. Visalia Medical Clinic has an opening for a BC/BE Neurological Surgeon to enter an immediate and active practice. Located in the San Joaquin Valley of California, serving a market area of approximately 350,000 citizens. Two Neurosurgeons presently serving this area. Excellent hospital services and facilities. Must be BC/BE. Compensation is incentive oriented with advancement to full partnership after one year. Excellent fringe benefits. John G. Heinsohn, Administrator, 5400 W. Hillsdale, Visalia, CA 93291; (209) 733-5222.

PHYSICIANS WANTED

OB/GYN. Multispecialty group in northwest Washington desires second Obstetrician. Excellent practice opportunity, full range of benefits, early partnership status, all practice costs paid. For more information contact Shane Spray, Administrator, 1400 E. Kincaid, Mount Vernon, WA 98273; (206) 428-2524.

PHYSICIANS WANTED IN TEXAS AND OKLAHOMA. Cardiology, Cardiovascular Surgery, Dermatology, ENT, Family Practice, General Surgery, Internal Medicine, OB/GYN, Orthopedic Surgery, Pulmonology, Urology. Excellent quality of life, first year guarantee, etc. Other opportunities available also. Reply with CV or call Armando L. Frezza, Medical Support Services, 8806 Balcones Club Dr, Austin, TX 78750; (512) 331-4164.

SOUTH CENTRAL WYOMING. Immediate practice opportunity for BC/BE Urologist. Well-equipped JCAH hospital for a service area of approximately 20,000 population. No state or city income tax. Relocation incentives. Superior hunting, fishing, camping, snowmobiling. Three hours to Colorado ski area, five hours to Jackson Hole. One and one-half hours to the mountains. If interested, please send CV and references to D. Abels, DO, Chairman, Recruiting Committee or Richard Mills, Executive Director, Memorial Hospital of Carbon County, Rawlins, WY 82301; (307) 324-2221.

ARIZONA-BASED PHYSICIAN recruiting firm has opportunities coast-to-coast. "Quality Physicians for Quality Clients since 1972." Call (602) 990-8080; or send CV to Mitchell & Associates, Inc, PO Box 1804, Scottsdale, AZ 85252.

DERMATOLOGIST. Visalia Medical Clinic has an opening for a BC/BE Dermatologist now staffed by one physician who has been with the Clinic for 15 years. Located in the San Joaquin Valley in central California and population approximately 350,000. Progressive city of 62,000, near national parks and the ocean. Compensation is incentive oriented with advancement to full partnership after one year. Excellent fringe benefits. If interested, CV to John G. Heinsohn, Administrator, 5400 W. Hillsdale, Visalia, CA 93291; (209) 733-5222.

PHYSICIANS WANTED

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Good People. Good Medicine.

NORTHERN CALIFORNIA

Several positions available for Family Practice, Internal Medicine, and most subspecialties. We are a young aggressive group in a well known HMO organization with excellent benefits and a very reasonable call schedule. You will enjoy the patient population with ample time to enjoy the mountains and San Francisco which are nearby. If interested please call or send CV to Physician Recruitment, Administration, Kaiser Permanente Medical Group, Inc, 1305 Tommydon St, Stockton, CA 95210; (209) 476-3300.

FAMILY PRACTICE in four season playground. Live, work, and play in beautiful north Idaho. Excellent professional opportunity. Private practice affiliated with JCAH accredited hospital. For details call Nancy collect at (208) 784-1221, ext 304. Shoshone Medical Center, Jacobs Gulch, Kellogg, ID 83837.

CALIFORNIA, SONORA. Staff Physician position available in 11-12,000 visit ER in quaint, historic, growing gold country community with fantastic recreational opportunities, one hour from Yosemite. Excellent opportunity in an academic and democratic group. Send CV to Art B. Wong, MD, FACEP, EPMG, 1 Maritime Plaza, Ste 710, San Francisco, CA 94111.

PHYSICIANS WANTED. A General Surgeon and an Oncologist to join 16 physician multispecialty group with attached 40-bed hospital located in southern Idaho. Contact Business Administrator, Box 1233, Twin Falls, ID 83301.

FAMILY PHYSICIAN. BC/BE to join the Family Practice department of a busy, primary care based multispecialty group. Excellent opportunity for growth. Contact Shane Spray, Administrator, Skagit Valley Medical Center, 1400 E. Kincaid, Mt. Vernon, WA 98273; (206) 428-2524.

PEDIATRICIAN position available with multispecialty group; BE/BC required; strong incentive plan; benefits included; retirement program and located in San Luis Obispo, California on the central coast. Send CV to Administration/Recruitment, San Luis Medical Clinic, 1235 Osos St, San Luis Obispo, CA 93401.

OBSTETRICIAN/GYNECOLOGIST position available with multispecialty group; BE/BC required; strong incentive plan; benefits included; retirement program and located in San Luis Obispo, California on the central coast. Send CV to Administration/Recruitment, San Luis Medical Clinic, 1235 Osos St, San Luis Obispo, CA 93401.

CENTRAL OREGON community seeks BE/BC Internist. 103-bed combination facility has ICU/CCU. Service area of 12,000. Coverage available by Internal Medicine group in neighboring town. Generous practice assistance package. An outdoorsman's winter and summer paradise! Contact Jean Erickson, PROSEARCH, 305 NE 102nd Ave, Portland, OR 97220; (503) 256-2070.

(Continued on Page 608)

CONTINUING MEDICAL EDUCATION

(Continued from Page 600)

November 10-13—**Sexual Literacy: What is it? What do we know? What do we need to know? Whose responsibility is it?** The Society for the Scientific Study of Sex at the Cathedral Hill Hotel, San Francisco. Thurs-Sun. Contact: Bernard Goldstein, San Francisco State University, Biology Dept., 1600 Holloway Ave., San Francisco, 94132. (415) 338-1548.

IDAHO

June 3—**Managing Major Radiation Accidents.** Idaho Falls Medical Society at University Place, Idaho Falls. Fri. 7 hrs. Contact: Kearny Poser, Idaho Falls Medical Society, 6991 Limousin Ave, Idaho Falls 83404. (208) 524-6370.

July 21-23—**Idaho Medical Association Annual Meeting.** Sun Valley. Thurs-Sat. Contact: IMA, 305 W. Jefferson, PO Box 2668, Boise 83701. (208) 344-7888.

August 29-30—**Northwest Regional Perinatal Conference—Current Issues in Ob/Gyn, Neonatology and Pediatrics.** Inland Empire Perinatal Center at Coeur d'Alene Resort. Contact: Inland Empire Perinatal Center, 411 Medical Center Bldg, Spokane, WA 99204. (509) 624-3182

MONTANA

September 29-October 1—**Montana Medical Association Annual Meeting.** Heritage Inn, Great Falls. Fri-Sat. Contact: MMA, 2012 11th Ave., Suite 12, Helena 59601. (406) 443-4000.

NEW MEXICO

Information, requests for accreditation and items to be listed should be sent to the chairman of the CME Committee, New Mexico Medical Society, 303 San Mateo NE, Suite 204, Albuquerque, NM 87108 at least two months in advance. For information on CME accreditation or on the CME requirements of the New Mexico Board of Medical Examiners, please write to the above address or call (505) 266-7868.

NOTE: Course information in the following listing is subject to change on occasion. Check with the sponsoring institution for current details.

May 17-22—**Basic Course in Otolaryngic Allergy.** Holiday Inn, Journal Center, Albuquerque. Tues-Sun. Contact: American Academy of Otolaryngic Allergy Foundation, 1101 Vermont, NW, Washington, DC 20005.

May 19-20—**Mental Health Services With Hispanic and Native American Children and Families.** Thurs-Fri. Contact: UNM SOM, Office of CME, (505) 277-3942.

June 2-3—**8th Annual UNM/ACEP Emergency Medicine Symposium.** AMFAC Hotel, Albuquerque. Thurs-Fri. Contact: UNM SOM, Office of CME, (505) 277-3942.

June 3—**Ethical Concerns in the Practice of Medicine—1988.** Memorial General Hospital, Las Cruces. Fri. Contact: Office of Medical Affairs, (505) 521-2218.

(Continued on Page 606)

WHEN ACID REFLUX ERUPTS

Zantac dramatically lessens pain of acid reflux[1] by inhibiting the formation of acid at its source–an action unique among pharmaceutical agents indicated for the treatment of gastroesophageal reflux disease.

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1. Sontag S, Robinson M, McCallum R, et al. Ranitidine therapy for gastroesophageal reflux disease. Results of a large double-blind trial. *Arch Intern Med* 1987; 147:1485–1491.

See next page for Brief Summary of Product Information.

Glaxo / ROCHE

(Continued from Page 602)

PHYSICIANS WANTED

INTERNIST with interest in trauma, Cardiology, or Gastroenterology, also willing to practice general Internal Medicine in a prosperous family-oriented community in southeastern New Mexico. Please submit CV to Rita Longino, Southwest Community Health Services, PO Box 26666, Albuquerque, NM 87125-6666; or call 1 (800) 545-4030, ext 8300.

FAMILY PHYSICIANS sought to join established physicians or develop solo practices in prosperous communities in New Mexico and Colorado. Please submit CV to Rita Longino, Southwest Community Health Services, PO Box 26666, Albuquerque, NM 87125-6666; or call 1 (800) 545-4030, ext 8300.

GENERAL PRACTICE. Busy medical center needs full-time physicians for urgent appointments. Significant evening and weekend hours. Abundant free time with no on-call responsibility. Excellent benefits and retirement program. Kaiser Permanente, Santa Teresa Hospital, 250 Hospital Pkwy, San Jose, CA 95119; (408) 972-6180.

PRIMARY CARE, INTERNIST, OR FAMILY PRACTITIONER who is BC/BE for satellite clinic in a rural community 30 minutes from main clinic, which is a 35 physician multispecialty group. Guaranteed income plus excellent benefits. No investment required. Send CV to Search Committee, Walla Walla Clinic, 55 W. Tietan, Walla Walla, WA 99362.

GASTROENTEROLOGIST. Second Gastroenterologist wanted for rapidly growing HMO in northern California wine country. Send CV to Richard Permutt, MD, Permanente Medical Group, 401 Bicentennial Way, Santa Rosa, CA 95403-2192.

INTERNAL MEDICINE. BC/BE Internist to associate with three other BC Internists in central California. No investment necessary. Minimal guarantee. Eventual loose partnership sharing personnel and expenses and call. Position available June 1, 1988. Excellent community for family life and unlimited recreation. Rapidly growing, stable economy. Send CV to Number 96, Western Journal of Medicine, PO Box 7602, San Francisco, CA 94120-7602.

GRANTS PASS, OREGON. Seeking BC/BE Family Practitioner to assume well-established Family Practice. Includes OB. Share call with four BC Family Practitioners. Located in all-American city on the Rogue River in southern Oregon. Contact Dan Gleffe, MD, 1587 NW Washington Blvd, Grants Pass, OR 97526; (503) 476-0801.

GENERAL INTERNIST—IDAHO. BE/BC to join four established Internists in primary care/consultation practice with wide variety of intensive care. Excellent public school system and four-year college. Immediate opening. Send CV to CIMPA, 222 E. Elm St, Caldwell, ID 83605.

INTERNIST BC/BE to be second Internist in a satellite of a 36 physician multispecialty clinic. Guaranteed salary and immediate full participation in incentive program. Excellent benefit package and excellent recreational, cultural, and educational opportunities. Send CV to Search Committee, Walla Walla Clinic, 55 W. Tietan, Walla Walla, WA 99362.

INTERNIST NEEDED. General or subspecialty to join established, private Internal Medicine practice. South-central rural Washington state. Good opportunity for right person. For more information, call M. S. Nusholtz, DO, (509) 837-8399.

PHYSICIANS WANTED

CARDIOLOGIST, NON-INVASIVE, BC/BE to join six physician group in the Portland metropolitan area—one Cardiologist, one Hematologist/Oncologist, two Gastroenterologists, two Internists. Send CV to Hudson's Bay Medical Group, Inc, PS, 2102 E. McLoughlin Blvd, Vancouver, WA 98661; (206) 695-1334.

PSYCHIATRIST. Knoxville VA Medical Center is actively recruiting for a staff Psychiatrist (full or part-time). Our center has four acute General Psychiatry units, chemical dependency treatment program, therapeutic living unit. If you want to work in a peaceful, relaxed community and get that hometown feeling, then Knoxville is the place for you. Excellent salary and benefits, including attractive retirement plan, 30 days paid vacation, health and life insurance, thrift savings plan (similar to 401K), and malpractice coverage. Require licensure any state. EOE. Contact Chief of Staff (11), VA Medical Center, 1515 W. Pleasant, Knoxville, IA 50138; (515) 842-3101, ext 6006.

SAN FRANCISCO BAY AREA. Multiracial community clinic full-time BC/BE Family Practitioner/Primary Care Internist to join three MDs and six Physician Assistants in providing high quality care to an underserved population. Send CV to Medical Director, Martin Luther King Jr Clinic, 101 Broadway, Richmond, CA 94804.

CALIFORNIA, SAN FRANCISCO BAY AREA. Full-time career Emergency Physician wanted for high volume Emergency Department. Emergency Medicine Board certified or Board-ready mandatory to participate in a group of twenty full-time staff physicians seeing over 300 patients per day. Salaried position, excellent benefits include three weeks paid vacation, one week CME, paid malpractice, health and life insurance, corporate shareholdership in three years. Send CV or contact David Gallagher, MD, 27400 Hesperian Blvd, Hayward, CA 94545.

INTERNIST, BC/BE to join six physician group in Portland metropolitan area—one Cardiologist, one Hematologist/Oncologist, two Gastroenterologists, two Internists. Send CV to Hudson's Bay Medical Group, Inc, PS, 2102 E. McLoughlin Blvd, Vancouver, WA 98661; (206) 695-1334.

CALIFORNIA. BE/BC Internist to join staff of eight Internists in 14 physician multispecialty group located in central San Joaquin Valley. Competitive starting salary and full benefits. Excellent living and practice environment. Send CV to Frank Kelley, MD, Kaweah Medical Group, 222 W. Willow, Visalia, CA 93291.

UROLOGIST BC/BE. To be second Urologist in a 35 physician multispecialty clinic. Guaranteed salary and immediate full participation in incentive program. Excellent benefit package and excellent recreational, cultural, and educational opportunities. Send CV to Search Committee, 55 W. Tietan, Walla Walla, WA 99362.

OREGON. INTERNIST BC/BE needed in busy four person group in dry part of state, town 14,000. Great place to live and work. CV to N. Sitz, MD, 1100 Southgate, Suite #2, Pendleton, OR 97801; (503) 276-1911.

FAMILY PRACTICE/GENERAL PRACTICE wanted for full-time practice to work three days a week and share with another Practitioner. Rural setting, good pay, nice people. Can commute for two nights a week, one hour Sacramento, one hour and 15 minutes Nevada City, two hours San Francisco. Contact Charles Rath, MD, 199 E. Webster St, Colusa, CA 95932; (916) 458-7739.

(Continued on Page 610)

(Continued from Page 608)

PHYSICIANS WANTED

PHYSICIANS
Ambulatory Care Clinics

John Short & Associates, Inc., an internationally recognized health care management and consulting firm, is actively seeking **PHYSICIANS** with experience and credentials in **FAMILY MEDICINE/GENERAL PRACTICE** and **PRIMARY CARE SPECIALTIES.**

Full or part-time positions are available in San Diego to staff an existing Primary Care Clinic. In addition, JSA is accepting CV's in preparation for potential sites in the Sacramento & Riverside areas. Qualifications, except for General Practitioners, include Board Certification or Board Eligibility.

John Short & Associates, Inc. offers competitive compensation including paid malpractice insurance, professional development funding and incentive programs. **For additional information please contact: Susan Bray, Recruiting Director, John Short & Associates, Inc., Box 1305, Columbia, MD 21044.**

E/O/E

GENERAL SURGEON, BE/BC. Outstanding opportunity for aggressive Surgeon with a highly profitable, well-established, fee-for-service, multispecialty clinic. 14 physicians on staff. Ready made practice. Unmatchable guaranteed salary first year, then ownership. New hospital. Wonderful family town with nationally recognized school system and unequalled outdoor recreation possibilities. Telephone calls will not be accepted. Send CV to John Brust, Mesaba Clinic, 1814 14th Ave East, Hibbing, MN 55746.

GASTROENTEROLOGIST position available with multispecialty group; BE/BC required; strong incentive plan; benefits included; retirement program and located in San Luis Obispo, California on the central coast. Send CV to Administration/Recruitment, San Luis Medical Clinic, 1235 Osos St, San Luis Obispo, CA 93401.

FAMILY PRACTITIONER position available with multispecialty group; BE/BC required; strong incentive plan; benefits included; retirement program and located in San Luis Obispo, California on the central coast. Send CV to Administration/Recruitment, San Luis Medical Clinic, 1235 Osos St, San Luis Obispo, CA 93401.

GENERAL INTERNIST position available with multispecialty group; BE/BC required; strong incentive plan; benefits included; retirement program and located in San Luis Obispo, California on the central coast. Send CV to Administration/Recruitment, San Luis Medical Clinic, 1235 Osos St, San Luis Obispo, CA 93401.

NEW MEXICO. BC/BE Primary Care Physician for 500-bed Psychiatric/Geriatric hospital. Exciting programs in an exciting location, with superb climate, recreational, and cultural benefits. Base salary $70,017 plus optional on-call salary supplement to $10,000. Fringe benefits are 21%, including paid malpractice and license fees, 2.5% per year retirement. Contact Philip Taulbee, MD, Medical Director, Las Vegas Medical Center, Box 1388, Las Vegas, NM 87701; (505) 454-2401.

PHYSICIANS WANTED

FULL AND PART-TIME PHYSICIANS

For Acute Ward Expansion in Large Geriatric Facility
Send CV to:
Medical Director
Laguna Honda Hospital
375 Laguna Honda Blvd
San Francisco, CA 94116
(415) 664-1656
EOE M/F/H

AGGRESSIVE, BC or recently Board eligible Internist needed for fee-for-service, multispecialty group. New, fully equipped, 150-bed hospital with heliport. The area has excellent recreational facilities and superb family environment with a nationally recognized school system. Subspecialty support is provided under a University of Minnesota affiliation. Send CV to Mesaba Clinic, 1814 14th Ave East, Hibbing, MN 55746; Attention: J. Brust.

PEDIATRICIAN, BC/BE. Interest in Neonatology preferred. Attractive salary and benefits. Partnership available in two years. Busy practice in agricultural community one-and-one-half hours from San Diego, California. Reply with CV to Drs Mirza R. Baig and Mohammad I. Admani, PO Box 590, El Centro, CA 92243.

IDAHO. Enjoy the great outdoors and an active, interesting Family Practice, including Obstetrics. Join four physicians and nine nurse practitioners working in rural community health centers near Boise. Emphasis on prevention. Good specialist back-up. Available now. Contact Erwin Teuber, Administrator, or Peter Barnett, MD, Medical Director, Terry Reilly Health Services, 211 16th Avenue North, Nampa, ID 83651; (208) 467-4431.

ESTABLISHED BC FAMILY PRACTITIONER in south central Washington seeks BE/BC associate with OB interest. Practice in rural, family-oriented community serving area of 45,000. Income guarantee and assistance with relocation. Ski at White Pass. Fishing and other water sports on nearby Rimrock Lake and Columbia River. Contact PROSEARCH, 305 NE 102nd Ave, Portland, OR 97220; (503) 256-2070, ext 202.

SOUTH CENTRAL WASHINGTON COMMUNITY seeks BE/BC Internist for solo practice. Share office space with two other physicians. First year income guarantee and other assistance. Great income potential for right candidate! Progressive 38-bed hospital has CT services. Excellent schools and recreation. Contact PROSEARCH, 305 NE 102nd Ave, Portland, OR 97220; (503) 256-4488.

FAMILY PRACTICE PHYSICIANS—Discover the magic of the southwest. Experience New Mexico! Outstanding career opportunities for BC/BE Family Practitioners. Obstetrics preferred, malpractice paid. Contact your physician consultant at New Mexico Health Resources, PO Box 27650, Albuquerque, NM 87125; (505) 242-0633. No fee.

WYOMING

Family Practice Physician BC/BE with interest in Obstetrics sought to join three Family Practice Physicians in community health clinic, hospital based. Located in the beautiful Big Horn Mountains, in community of 3,800 population, service area 6,200. Multiple outdoor activities available. Send CV to:
Sandy Ward, Administrator
497 W Lott
Buffalo, WY 82834
or call (307) 684-5521

PHYSICIANS WANTED

PRACTICE OPPORTUNITIES— PACIFIC NORTHWEST

Group practice opportunities available for BC/BE physicians in DERMATOLOGY, ENDOCRINOLOGY, INFECTIOUS DISEASE, ONCOLOGY, and RHEUMATOLOGY. Multispecialty group of Internists and Internal Medicine subspecialists is expanding.

Candidates must have strong clinical *and* interpersonal skills. The position offers a competitive salary plus incentives.

Bellingham is located in northwestern Washington state on Puget Sound, two hours from Seattle and one hour from Vancouver, BC. The population of Bellingham is 55,000 and the service area population is 125,000 including the San Juan Islands. The area offers outstanding outdoor recreational activities including sailing, skiing, hunting, fishing, and hiking. Bellingham is the home of Western Washington University and offers many cultural and educational opportunities.

For more information:
Send CV or contact Patty House
Health Resource Services Group
1200 5th Ave, Suite 2000
Seattle, WA 98111
(206) 223-6351.

30 MEMBER MULTISPECIALTY, San Francisco bay area private practice group seeks second Orthopaedist to join existing one, starting July 1988. Must be BE/BC. Incentive based income. Submit CV to Michael E. Sondel, CEO, Family Doctor Medical Group, 1617 Broadway, Vallejo, CA 94589-2495; (707) 553-6023.

OCCUPATIONAL/FAMILY PRACTICE. Excellent opportunities with west coast's leading provider of Occupational/Family Practice medicine. Full/part-time positions throughout California and Washington (Seattle/Tacoma). Current license/CPR. Prior outpatient/family practice/industrial-type trauma experience. Attractive salary/incentives/benefits/malpractice. Contact Personnel Director, ReadiCare, Inc, 446 Oakmead Pkwy, Sunnyvale, CA 94086; (800) 237-3234. Join our dynamic team of professionals. Practice and live in an incomparable environment.

PEDIATRICIAN—SUNNY SOUTHERN CALIFORNIA. Rapidly growing, family oriented community at the foot of the mountains near Palm Springs needs another Pediatrician. Beautiful hospital expanding its services will provide financial guarantee for the right BE/BC physician. For more information and a personal interview, please call Jeffrey Gowan at (800) 288-1210 and/or send your CV to Merritt, Hawkins & Associates, 500 N. Newport Blvd, Ste 204, Newport Beach, CA 92663.

FAMILY PRACTITIONER. BE/BC Family Practitioner with knowledge of Spanish to become shareholder and partner with 20 plus MD multispecialty group. Training important. Guarantee salary, malpractice insurance, health insurance, plus. Send CV to Number 98, Western Journal of Medicine, PO Box 7602, San Francisco, CA 94120-7602.

INTERNIST NEEDED FULL-TIME. Primary Care position for Board certified Internist is now available with a growing San Francisco Health Plan. The position includes both inpatient and outpatient responsibilities. Send CV to Medical Director, French Health Plan, 4131 Geary Blvd, San Francisco, CA 94118.

(Continued on Page 614)

CONTINUING MEDICAL EDUCATION

(Continued from Page 609)

May 26-27—**Alzheimer's Disease.** Seattle. Thurs-Fri. Contact: U/W, Maria Lilja, (206) 543-1050.

June 3—**Topics in General Internal Medicine.** Seattle. Fri. Contact: VMMC.

June 9—**Health Care and Anti-Trust.** Seattle. Thurs. Contact: U/W, Maria Lilja, (206) 543-1050.

June 9-10—**Update in Clinical Neurology.** Seattle. Thurs-Fri. Contact: Northwest Hospital, (206) 364-0500, Ext 1621.

June 9-11—**Obstetric Ultrasound.** Seattle. Thurs-Sat. Contact: Robin Murray, (202) 863-2543.

June 17-18—**Renal Disorders: Medical and Surgical Aspects.** Seattle. Fri-Sat. Contact: U/W, Maria Lilja, (206) 543-1050.

June 20-24—**Pathology of Lung Cancer.** Seattle. Mon-Fri. Contact: VMMC.

July 22-24—**First International Symposium on Pediatric Pain.** Seattle. Fri-Sun. Contact: U/W, Maria Lilja, (206) 543-1050.

July 29-31—**Seafair Anesthesia X.** Seattle. Fri-Sun. Contact: VMMC.

COURSE SPONSORS AND CONTACT INFORMATION

CME HARBORVIEW—Contact: Gayle Splater, Cytology Continuing Education, Dept. of Pathology, Harborview Medical Center, 325 Ninth Avenue, Seattle, WA 98104. (206) 223-5953.

CME PIERCE COUNTY—Contact: Mrs Maxine Bailey, Executive Director, College of Medical Education, 705 South Ninth, No. 203, Tacoma, WA 98405. (206) 627-7137.

U/W (UNIVERSITY OF WASHINGTON)—Contact: U/W School of Medicine, Div. of CME, SC-50, Seattle, WA 98195. (206) 543-1050.

WSMA—Washington State Medical Association, Continuing Medical Education, 2033 Sixth Ave, Suite 900, Seattle, WA 98121. (206) 441-9762.

VMMC (VIRGINIA MASON MEDICAL CENTER)—Contact: Linda Orgel, Division of Continuing Medical Education, Virginia Mason Medical Center, PO Box 900, Seattle, WA 98111. (206) 223-6898.

August 1-5—**Postgraduate Seminar in Psychology: Modern Approaches to Psychological Interviewing.** Ellensburg. Mon-Fri. Contact: Central Washington University, (509) 963-2381.

August 5—**Otology Update.** Seattle. Fri. Contact: VMMC.

August 8-14—**Summer Seminar in Medical Ethics and History.** Seattle. Mon-Sun. Contact: U/W, Maria Lilja, (206) 543-1050.

August 11-12—**Surviving the Elements.** Seattle. Thurs-Fri. Contact: U/W, Maria Lilja, (206) 543-1050.

August 29—**NW Regional Perinatal Conference: Current Issues in OB/GYN, Neonatology and Pediatrics.** Coeur d'Alene, Idaho. Thurs. Contact: (509) 624-3182.

August 31-September 3—**Second International Forum of Otorhinolaryngology.** Seattle. Wed-Sat. Contact: U/W, Maria Lilja, (206) 543-1050.

September 17-24—**Effective Management of Common Sports Injuries.** San Juan Islands. Sat-Sat. Contact: Kathy Rairigh, EPIC Expeditions, (208) 788-4995.

September 22-24—**Orthopedic Biomechanics.** Seattle. Thurs-Sat. Contact: VMMC.

WYOMING

June 23-26—**Wyoming Medical Society Annual Meeting.** Jackson Lake Lodge, Moran. Thurs-Sun. Contact: WMS, PO Drawer 4009, Cheyenne 82003-4009. (307) 635-2424.

July 18-22—**6th Annual Update in Clinical Microbiology and Immunology.** University of Utah Medical Center at Jackson Hole. Mon-Fri. 25 hrs. Contact: UUMC, 50 N Medical Dr, Salt Lake City, UT 84132. (801) 581-2258. ◆

THE ARIZONA MEDICAL ASSOCIATION, INC.

ANNUAL MEETING AND SCIENTIFIC PROGRAM SCHEDULE

JUNE 9 — 11, 1988 • LOEWS VENTANA CANYON RESORT • TUCSON, ARIZONA

SCHEDULE OF EVENTS

Thursday, June 9, 1988

Current Perspectives Programs

8:00 AM – 12 Noon	Legal/Ethical	Salons J & K
	Infectious Diseases	Salons H & I
	Nuclear	Salon L

Current Perspectives Programs

1:00 PM – 5:00 PM	Musculoskeletal Disorders	Salons J & K
	Pharmacotherapeutics	Salons H & I
	Nuclear	Salon L
1:00 PM – 5:00 PM	Hospital Medical Staff Section Program and Annual Meeting	Coronado
1:00 PM – 5:00 PM	Arizona Chapter, American College of OB/GYN	Pavilion A
7:00 PM	"An Evening with Mark and Marv" Reception and Steak Fry	BBQ Area

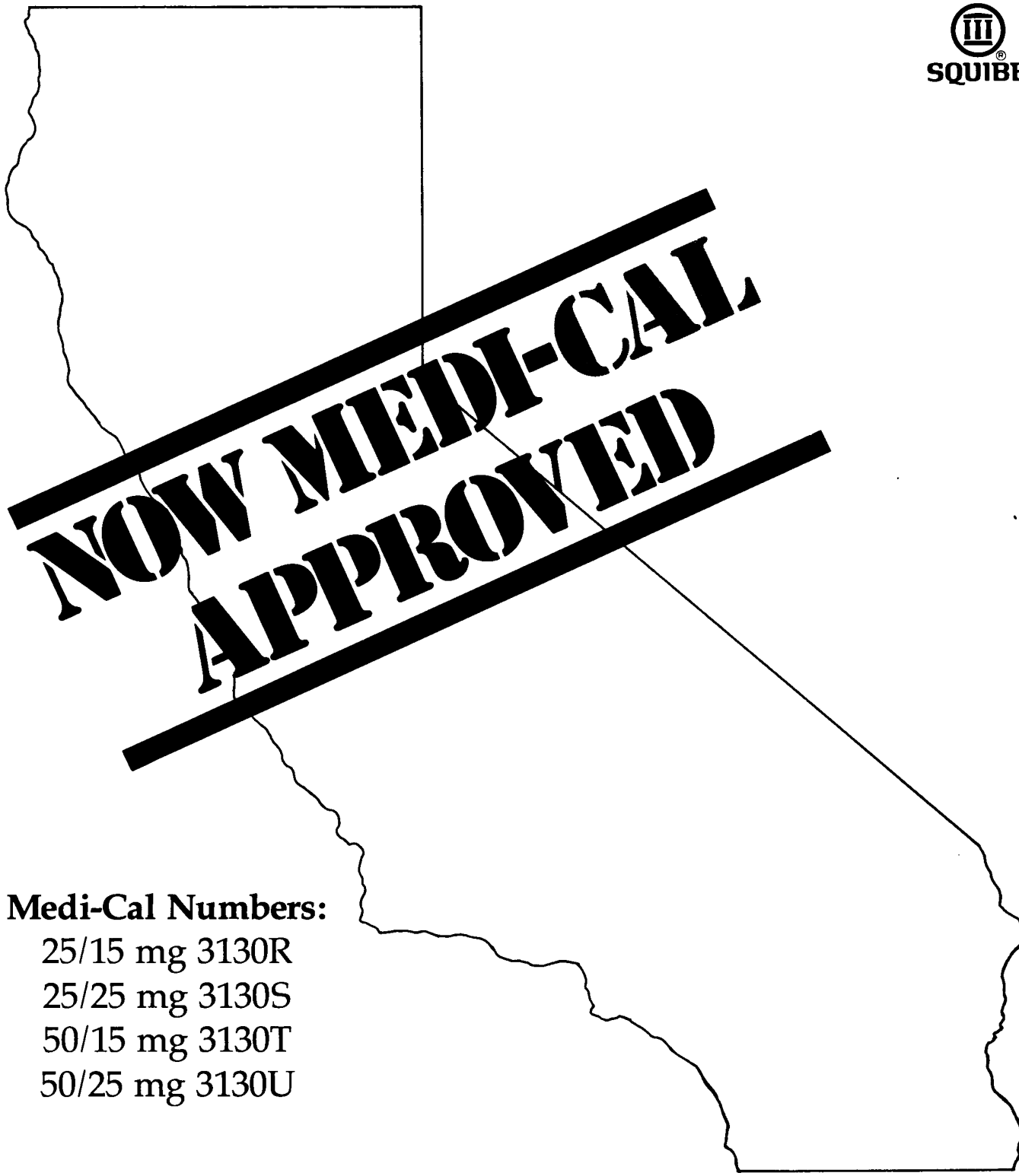
Friday, June 10, 1988

6:00 AM – 8:00 AM	Executive Committee Breakfast	Executive Boardroom
8:00 AM – 10:00 AM	Board of Directors' Meeting	Salon D
10:00 AM – 12 Noon	House of Delegates	Salon B
12 Noon – 4:00 PM	Past Presidents' Luncheon	Saguaro
2:00 PM – 5:00 PM	Amendments Reference Committee	Salon D
2:00 PM – 5:00 PM	Resolutions Reference Committee	Salon K
7:00 PM	President's Reception	Foyer
8:00 PM	President's Banquet	Salons B & C

Saturday, June 11, 1988

6:30 AM – 8:00 AM	Maricopa County Caucus	Rincon
6:30 AM – 8:00 AM	Pima County Caucus	Coronado
8:00 AM – 12 Noon	House of Delegates	Salon B
12 Noon – 3:00 PM	Board of Directors' Luncheon	Coronado

For further information or registration material, please contact the Arizona Medical Association, (602) 246-8901.



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25/25 mg 3130S
50/15 mg 3130T
50/25 mg 3130U

Capozide
Captopril/HCTZ

538-509

Issued: May 1988

(Continued from Page 610)

PHYSICIAN WANTED

Physicians wanted for leading clinic

Prestigious Chicago-based clinic group specializing in the treatment of venous disorders is expanding nationally. Our newest clinics in Los Angeles, San Francisco, Seattle, San Diego and Phoenix are in need of physicians trained in internal medicine—or who have a broad base of medical experience. We will provide complete training in the latest proprietary techniques of treating venous disorders. We offer a six figure salary and bonus potential, along with malpractice insurance and health benefits. And since there are no weekend hours and a 40-hour work week, you will have plenty of leisure time. You won't have to worry about soliciting for patients or fighting insurance companies.

This is an outstanding opportunity for professional and financial advancement. If you are motivated to build a rewarding practice with the leader in the treatment of venous disorders, send your resume to:

Medical Director

Vein Clinics of America

2340 S. Arlington Heights Road
Arlington Heights, Illinois 60005

30 MEMBER MULTISPECIALTY, San Francisco bay area private practice group seeks Pediatrician starting July 1988. Must be BE/BC. Incentive based income. Submit CV to Michael E. Sondel, CEO, Family Doctor Medical Group, 1617 Broadway, Vallejo, CA 94589-2495; (707) 553-6023.

THE TOWN OF TRINIDAD, COLORADO is currently looking for a Family Practitioner/General Practitioner and Internal Medicine Specialist for private practice openings. Trinidad is located approximately 80 miles south of Pueblo, Colorado on the Front Range of the Rocky Mountains. The area enjoys an excellent climate with a great deal of recreational activities. Also, skiing is available within 45 minutes at Cuchara Valley Ski Area. Interested individuals should contact Ron Shafer, Administrator, Mount San Rafael Hospital, 410 Benedicta Ave, Trinidad, CO 81082; (719) 846-9213.

OUTSTANDING OPPORTUNITY. General Internist, BE/BC, and Oncologist with Internal Medicine strength. Private practice or affiliation available, San Francisco north bay area community. Send résumé to Number 84, Western Journal of Medicine, PO Box 7602, San Francisco, CA 94120-7602.

PHYSICIANS WANTED

SAN DIEGO STATE UNIVERSITY
Student Health Services—Physician II

Ten month position. BC required. Family Practice strongly preferred. Salary range $5,488 to $6,642 per month. Send letter of interest and CV to Ralph Hernandez, MD, Chief of Clinical Services, Student Health Services, San Diego State University, San Diego, CA 92182.

ORTHOPEDIST. The west coast's leading Occupational/Family Practice medical provider has full-time/part-time opportunities for Orthopedic Specialists in California and Washington (Seattle/Tacoma). Attractive package includes guaranteed salary, incentive bonus, and benefits. Current license. Contact Personnel Director, ReadiCare, Inc, 446 Oakmead Pkwy, Sunnyvale, CA 94086; (800) 237-3234. Join our dynamic team of professionals. Practice and live in an incomparable environment.

30 MEMBER MULTISPECIALTY, San Francisco bay area private practice group seeks non-invasive Cardiologist starting July 1988. Must be BE/BC. Incentive based income. Submit CV to Michael E. Sondel, CEO, Family Doctor Medical Group, 1617 Broadway, Vallejo, CA 94589-2495; (707) 553-6023.

PEDIATRICIAN. BE/BC Pediatrician with knowledge of Spanish to become shareholder and partner with 20 plus MD multispecialty group. Training important. Guarantee salary, malpractice insurance, health insurance, plus. Send CV to Number 99, Western Journal of Medicine, PO Box 7602, San Francisco, CA 94120-7602.

INTERNIST, BC/BE, to join two member primary care clinic, suburb, Seattle, Washington. Spacious, new office near top rate hospital. Send letter of career goals, interests, and CV to Number 100, Western Journal of Medicine, PO Box 7602, San Francisco, CA 94120-7602.

ACADEMIC EMERGENCY PHYSICIAN. Unique position combining half-time academic attending at University of Washington, University Hospital Emergency Department and half-time Medical Advisor to King County Paramedic Program. Responsibilities as attending include supervision of housestaff and medical students, clinical care, and teaching. Responsibilities as Medical Advisor include assisting the manager of the King County Emergency Medical Services Division, working with local paramedic medical directors to ensure consistency and coordination in the provision of services, develop and assist in EMS training programs and continuing education, assist in evaluation research of new or existing medical treatments, and represent the Division with the local medical community and professional regulatory agencies. Qualifications include BE/BC Internal Medicine, experience in Emergency Medicine and emergency medical services. Appointment is in the Department of Medicine, University of Washington. Rank and salary dependent upon qualifications. Female and minority candidates are encouraged to apply. Send letter of interest and CV to Mickey Eisenberg, MD, PhD, Emergency Medicine Service, University Hospital, RC-02, 1959 NE Pacific St, Seattle, WA 98195.

30 MEMBER MULTISPECIALTY, San Francisco bay area private practice group seeks Pediatrician or Family Practice Physician for urgent or episodic primary care outpatient clinic. Full-time. Must be BE/BC. Incentive based income. Submit CV to Michael E. Sondel, CEO, Family Doctor Medical Group, 1617 Broadway, Vallejo, CA 94589-2495; (707) 553-6023.

INVASIVE CARDIOLOGIST. Aggressive catheterizing BC/BE Cardiologist wanted for expansion of practice in California's central valley. Base salary and incentives depending on experience with potential for early partnership. Please respond with CV to Box 3211, Modesto, CA 95353.

PHYSICIANS WANTED

SOUTHERN CALIFORNIA

Enjoy professional challenge and growth with a successful and expanding HMO in Southern California. CIGNA Healthplans of California is seeking Specialists and Primary Care Physicians committed to concepts of prevention and health maintenance to join our facilities in Los Angeles and Orange Counties. We offer an excellent compensation and benefits package including profit sharing. For consideration, please forward CV to:

Director/Physician Recruitment
CIGNA Healthplans of California
505 N. Brand Blvd, Suite 400-49
Glendale, CA 91203

OPENINGS for one or two General and one Vascular Surgeon in 175 physician, multispecialty group. Offices adjacent to modern 230-bed hospital in suburbs of south San Jose near excellent recreational facilities. Competitive salary, generous fringe benefits including paid educational leave, vacation, insurance, and retirement. Contact Latimer H. Booth, MD, Chief, Department of Surgery, The Permanente Medical Group, Inc, 260 International Cir, San Jose, CA 95119.

SEVERAL OPENINGS AVAILABLE for Family Practitioners throughout western and central North Dakota. This large multispecialty group is seeking physicians for several satellites. All positions include a lucrative salary guarantee, full benefit package, and coverage. For more information, contact Durham Medical Search, Inc, 6300 Transit Rd, PO Box 478, Depew, NY 14043; or call 1 (800) 633-7724.

EUGENE, OREGON. Well-established, eight physician Family Practice group is seeking BC/BE Family Physician with interest in OB. Anticipate partnership after one year. Exceptional cultural and recreational opportunities. Home of the University of Oregon. Please send CV to Rob Daugherty, MD, River Road Medical Group, 2400 River Rd, Eugene, OR 97404; or call (503) 688-7527.

OB/GYN—SUNNY SOUTHERN CALIFORNIA. Rapidly growing, family oriented community at the foot of the mountains near Palm Springs needs another OB/GYN. Beautiful hospital expanding its services will provide financial guarantee for the right BE/BC physician. For more information and a personal interview, please call Jeffrey Gowan at (800) 288-1210 and/or send your CV to Merritt, Hawkins & Associates, 500 N. Newport Blvd, Ste 204, Newport Beach, CA 92663.

WASHINGTON. Full-time Emergency Physician needed for moderate volume ED in Yakima area. $100,000 possible plus partial malpractice coverage. Near mountains, skiing, etc. Two and one-half hours from Seattle. Send CV to Ted Palmatier, MD, FACEP, 110 S. Ninth Ave, Yakima, WA 98902; or call (509) 575-5060.

FAMILY PRACTICE PHYSICIAN. Full-time in a busy walk-in medical clinic. Located in Visalia, California (Tulare County). Malpractice insurance, salary and ECT. Please call (209) 627-5555 for more information.

GENERAL SURGEON. Opportunity for BC/BE Surgeon with fellowship or experience in Vascular Surgery to join Surgeon in active practice in southeastern Washington state; well-equipped 71-bed hospital undergoing expansion. Send current CV to J. Griffith, PO Box 6128, Kennewick, WA 99336.

CALIFORNIA

Primary Care Physicians needed to work as *locum tenens* in northern California. Radiologists needed statewide. High salary, paid malpractice. Work whenever you like. Permanent placements as well.

Contact Carol Sweig, Director, (415) 673-7676. Western Physicians Registry, 710 Van Ness Ave, San Francisco, CA 94102.

PHYSICIANS WANTED

FAMILY PRACTICE

Excellent opportunity for Family Physician to replace one associate who is retiring. Established Family Practice in Norwalk, California, will guarantee basic salary plus percentage. Partnership a possibility.

(213) 868-7706

INTERNAL MEDICINE. A BC/BE Internist with/without subspecialty needed to join busy practice of two BC Internists in growing town on beautiful coast of northern California. Outdoor activities unlimited, great setting for family life. New state employer. Practice half hospital-based (new facility in two years) with full range ICU procedures and half office-based. Frequent consultations. Salary guarantee, benefits package, profit sharing, early partnership potential. Call or write John H. Jackson, MD, 200 A St, Ste B, Crescent City, CA 95531; (707) 464-8331.

PHYSICIAN OPENING. Ambulatory care/minor emergency center. Full/part-time for Family Practice/Internal Medicine/Emergency Medicine trained, experienced physician located in Tacoma area. Flexible scheduling, pleasant setting, quality medicine. Contact David R. Kennel, MD, 5900 100th St Southwest, Ste 31, Tacoma, WA 98499; (206) 584-3023 or 582-2542.

ONCOLOGIST/INTERNIST BC/BE wanted to join hospital-based multispecialty clinic near San Francisco. Complete benefit package. Send résumé to Gary Hillman, MD, Chief, Department of Medicine, Permanente Medical Group, 1150 Veterans Blvd, Redwood City, CA 94063; or call (415) 780-2626.

FAMILY PRACTICE—SUNNY SOUTHERN CALIFORNIA. Rapidly growing, family oriented community at the foot of the mountains near Palm Springs needs another Family Practitioner. Beautiful hospital expanding its services will provide financial guarantee for the right BE/BC physician. For more information and a personal interview, please call Jeffrey Gowan at (800) 288-1210 and/or send your CV to Merritt, Hawkins & Associates, 500 N. Newport Blvd, Ste 204, Newport Beach, CA 92663.

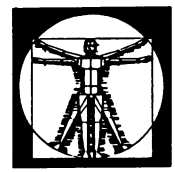
INTERNIST. We are seeking a BC/BE Internist with a special interest in Cardiology to join a university-affiliated, hospital and clinic-based, primary patient care group. Clinical skills in an ICU/CCU setting are important, as well as the ability to interact with an 18 member Family Practice Residency Program. Send CV to John Schatz, MD, Chief, Department of Cardiology, Natividad Medical Center, 1330 Natividad Rd, Salinas, CA 93906.

WASHINGTON. Excellent opportunity for caring BC/BE physician to join a 35 member multispecialty clinic as the second physician in our expanding facility based Immediate Care Department. Competitive salary and generous fringe benefits including paid education leave, vacation, insurance, and retirement. Send inquiries and CV to R. G. Caudill, MD, Walla Walla Clinic, 55 W. Tietan, Walla Walla, WA 99362.

OB/GYN—IDAHO-SUN VALLEY. Skiing is one of the benefits of having your practice in this recreation-rich area. Hospital is expanding its OB/GYN services and needs one to two BE/BC hardworking OB/GYNs to service this area. Big practice. Support of excellent, quality medical staff. For more information call Jeffrey Gowan at (800) 288-1210 and/or send CV to 500 N. Newport Blvd, Ste 204, Newport Beach, CA 92663.

MEDICAL DIRECTOR/FAMILY PHYSICIAN, San Francisco bay area. Community clinic needs part-time Medical Director, flexible hours, with clinical and administrative duties. Competitive pay, malpractice provided. Contact Lisa Jafferies, 2470 Alvin Ave, #3, San Jose, CA 95121; (408) 274-8400. Start date—summer.

MedSearch & Associates



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WESTERN REGION LISTINGS:

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P.O. Box 186
Walnut Creek, CA 94596
(415) 977-4349

PHYSICIANS WANTED

Western States OPENINGS

Many multispecialty groups and hospitals have asked us to recruit for over 300 positions of various specialties. Both permanent and locum tenens. Send CV to:
Western States Physician Services,
407 S. Clovis Ave, Ste 108, Fresno, CA 93727.
Or call (209) 252-3000.

INTERNIST, BC/BE, California license. Women's care clinic. Duties will include admissions and in-patient care. Send résumé to Dr Susann J. Steinberg, Medical Director, Access Health Care, 26 California St, San Francisco, CA 94111.

PHYSICIAN part-time for Internal Medicine practice in the East Bay. Residency training in Internal Medicine preferred. Malpractice insurance paid. Possible association in future. Call (415) 223-7901, or send CV to 4450 San Pablo Dam Rd, El Sobrante, CA 94803.

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PEDIATRICIAN, BE/BC, needed July 1988 in four-season playground. Excellent practice opportunity with positive financial success. Send CV to Dr Gerald E. Carlson, Women's Medical Clinic, 1203 10th St South, Nampa, ID 83651; (208) 467-2400.

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(Continued on Page 617)

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PHYSICIANS WANTED

PHYSICIAN WANTED. Family Practice Physician to join 16 physician multispecialty group with attached 40-bed hospital located in southern Idaho. Contact Business Administrator, Box 1233, Twin Falls, ID 83301.

INTERNISTS, OB/GYN, PEDIATRICIAN, ORTHOPEDIC SURGEONS and NEUROSURGEONS for private practice situations in Washington, Nevada, California, Louisiana, Florida, Texas. Most situations are with established physicians although some are hospital sponsored. For additional information, please contact Eloise Gusman, 1 (800) 535-7698 or (504) 893-4879 or send CV to PO Box 1685, Covington, LA 70434-1685.

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INTERNIST—SUNNY SOUTHERN CALIFORNIA. Rapidly growing, family oriented community at the foot of the mountains near Palm Springs needs another Internist. Beautiful hospital expanding its services will provide financial guarantee for the right BE/BC physician. For more information and a personal interview, please call Jeffrey Gowan at (800) 288-1210 and/or send your CV to Merritt, Hawkins & Associates, 500 N. Newport Blvd, Ste 204, Newport Beach, CA 92663.

FAMILY PRACTITIONER. Busy four physician Family Practice group (including OB) seeks replacement for partner departing fall, 1988. Located in Alaska's capital city in the Tongass National Forest offering year 'round recreation including skiing, boating, and hiking. Guaranteed salary with excellent fringe benefits and opportunity for partnership within one year. Send CV to Sarah A. Isto, MD, Valley Medical Care, Inc, 9309 Glacier Hwy, B-301, Juneau, AK 99801; (907) 789-3181.

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(Continued on Page 618)

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(Continued from Page 617)

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Rocephin® (ROCHE)® IV·IM

ceftriaxone sodium/Roche

Before prescribing, please consult complete product information, a summary of which follows:

INDICATIONS AND USAGE: Rocephin is indicated for the treatment of the following infections when caused by susceptible organisms:

LOWER RESPIRATORY TRACT INFECTIONS caused by *Strep. pneumoniae, Streptococcus* species (excluding enterococci), *Staph. aureus, H. influenzae, H. parainfluenzae, Klebsiella* species (including *K. pneumoniae*), *E. coli, E. aerogenes, Proteus mirabilis* and *Serratia marcescens*.

SKIN AND SKIN STRUCTURE INFECTIONS caused by *Staph. aureus, Staph. epidermidis, Streptococcus* species (excluding enterococci), *E. cloacae, Klebsiella* species (including *K. pneumoniae*), *Proteus mirabilis* and *Pseudomonas aeruginosa*.

URINARY TRACT INFECTIONS (complicated and uncomplicated) caused by *E. coli, Proteus mirabilis, Proteus vulgaris, M. morganii* and *Klebsiella* species (including *K. pneumoniae*).

UNCOMPLICATED GONORRHEA (cervical/urethral and rectal) caused by *Neisseria gonorrhoeae*, including both penicillinase and nonpenicillinase producing strains.

PELVIC INFLAMMATORY DISEASE caused by *N. gonorrhoeae*.

BACTERIAL SEPTICEMIA caused by *Staph. aureus, Strep. pneumoniae, E. coli, H. influenzae* and *K. pneumoniae*.

BONE AND JOINT INFECTIONS caused by *Staph. aureus, Strep. pneumoniae, Streptococcus* species (excluding enterococci), *E. coli, P. mirabilis, K. pneumoniae* and *Enterobacter* species.

INTRA-ABDOMINAL INFECTIONS caused by *E. coli* and *K. pneumoniae*.

MENINGITIS caused by *H. influenzae, N. meningitidis* and *Strep. pneumoniae*. Ceftriaxone has also been used successfully in a limited number of cases of meningitis and shunt infections caused by *Staph. epidermidis* and *E. coli*.

SURGICAL PROPHYLAXIS: Preoperative administration of a single 1 gm dose may reduce incidence of postoperative infections in patients undergoing surgical procedures classified as contaminated or potentially contaminated (*e.g.*, vaginal or abdominal hysterectomy) and in those for whom infection at the operative site presents serious risk (*e.g.*, during coronary artery bypass surgery).

Although ceftriaxone has been shown to have been as effective as cefazolin in the prevention of infection following coronary artery bypass surgery, no placebo-controlled trials have been conducted to evaluate any cephalosporin antibiotic in the prevention of infection following coronary artery bypass surgery. When administered before indicated surgical procedures, a single 1 gm dose provides protection from most infections due to susceptible organisms for duration of procedure.

SUSCEPTIBILITY TESTING: Before instituting treatment with Rocephin, appropriate specimens should be obtained for isolation of the causative organism and for determination of its susceptibility to the drug. Therapy may be instituted prior to obtaining results of susceptibility testing.

CONTRAINDICATIONS: Rocephin is contraindicated in patients with known allergy to the cephalosporin class of antibiotics.

WARNINGS: BEFORE THERAPY WITH ROCEPHIN IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE TO DETERMINE WHETHER THE PATIENT HAS HAD PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS, PENICILLINS OR OTHER DRUGS. THIS PRODUCT SHOULD BE GIVEN CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. ANTIBIOTICS SHOULD BE ADMINISTERED WITH CAUTION TO ANY PATIENT WHO HAS DEMONSTRATED SOME FORM OF ALLERGY, PARTICULARLY TO DRUGS. SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE THE USE OF SUBCUTANEOUS EPINEPHRINE AND OTHER EMERGENCY MEASURES.

Pseudomembranous colitis has been reported with the use of cephalosporins (and other broad-spectrum antibiotics), therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with antibiotic use.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis. Cholestyramine and colestipol resins have been shown to bind to the toxin *in vitro*.

Mild cases of colitis respond to drug discontinuance alone. Moderate to severe cases should be managed with fluid, electrolyte and protein supplementation as indicated.

When the colitis is not relieved by drug discontinuance or when it is severe, oral vancomycin is the treatment of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should also be considered.

Rarely, shadows suggesting sludge have been detected by sonograms of the gallbladder in asymptomatic and symptomatic patients. This appears to be reversible on discontinuation of therapy. In a few symptomatic patients receiving higher than usual doses, who underwent surgery, sludge containing traces of ceftriaxone was recovered from surgical specimens. Discontinue therapy in patients who develop signs or symptoms suggestive of gallbladder disease, consider conservative management.

PRECAUTIONS: *GENERAL*: Although transient elevations of BUN and serum creatinine have been observed, at the recommended dosages, the nephrotoxic potential of Rocephin is similar to that of other cephalosporins.

Ceftriaxone is excreted via both biliary and renal excretion (see Clinical Pharmacology). Therefore, patients with renal failure normally require no adjustment in dosage when usual doses of Rocephin are administered, but concentrations of drug in the serum should be monitored periodically. If evidence of accumulation exists, dosage should be decreased accordingly.

Dosage adjustments should not be necessary in patients with hepatic dysfunction, however, in patients with both hepatic dysfunction and significant renal disease, Rocephin dosage should not exceed 2 gm daily without close monitoring of serum concentrations.

Alterations in prothrombin times have occurred rarely in patients treated with Rocephin. Patients with impaired vitamin K synthesis or low vitamin K stores (*e.g.*, chronic hepatic disease and malnutrition) may require monitoring of prothrombin time during Rocephin treatment. Vitamin K administration (10 mg weekly) may be necessary if the prothrombin time is prolonged before or during therapy.

Prolonged use of Rocephin may result in overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Rocephin should be prescribed with caution in individuals with a history of gastrointestinal disease, especially colitis.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY: Carcinogenesis: Considering the maximum duration of treatment and the class of the compound, carcinogenicity studies with ceftriaxone in animals have not been performed. The maximum

duration of animal toxicity studies was six months.

Mutagenesis: Genetic toxicology tests included the Ames test, a micronucleus test and a test for chromosomal aberrations in human lymphocytes cultured *in vitro* with ceftriaxone. Ceftriaxone showed no potential for mutagenic activity in these studies.

Impairment of Fertility: Ceftriaxone produced no impairment of fertility when given intravenously to rats at daily doses up to 586 mg/kg/day, approximately 20 times the recommended clinical dose of 2 gm/day.

PREGNANCY: Teratogenic Effects: Pregnancy Category B. Reproductive studies have been performed in mice and rats at doses up to 20 times the usual human dose and have no evidence of embryotoxicity, fetotoxicity or teratogenicity. In primates, no embryotoxicity or teratogenicity was demonstrated at a dose approximately three times the human dose. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproductive studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nonteratogenic Effects: In rats, in the Segment I (fertility and general reproduction) and Segment III (perinatal and postnatal) studies with intravenously administered ceftriaxone, no adverse effects were noted on various reproductive parameters during gestation and lactation, including postnatal growth, functional behavior and reproductive ability of the offspring, at doses of 586 mg/kg/day or less.

NURSING MOTHERS: Low concentrations of ceftriaxone are excreted in human milk. Caution should be exercised when Rocephin is administered to a nursing woman.

PEDIATRIC USE: Safety and effectiveness of Rocephin in neonates, infants and children have been established for the dosages described in the Dosage and Administration section. *In vitro* studies have shown ceftriaxone, like some other cephalosporins, can displace bilirubin from serum albumin. Exercise caution before administration to hyperbilirubinemic neonates, especially prematures.

ADVERSE REACTIONS: Rocephin is generally well tolerated. In clinical trials, the following adverse reactions, which were considered to be related to Rocephin therapy or of uncertain etiology, were observed.

LOCAL REACTIONS—pain, induration or tenderness at the site of injection (1%). Less frequently reported (less than 1%) was phlebitis after I.V. administration.

HYPERSENSITIVITY—rash (1.7%). Less frequently reported (less than 1%) were pruritus, fever or chills.

HEMATOLOGIC—eosinophilia (6%), thrombocytosis (5.1%) and leukopenia (2.1%). Less frequently reported (less than 1%) were anemia, neutropenia, lymphopenia, thrombocytopenia and prolongation of the prothrombin time.

GASTROINTESTINAL—diarrhea (2.7%). Less frequently reported (less than 1%) were nausea or vomiting, and dysgeusia.

HEPATIC—elevations of SGOT (3.1%) or SGPT (3.3%). Less frequently reported (less than 1%) were elevations of alkaline phosphatase and bilirubin.

RENAL—elevations of the BUN (1.2%). Less frequently reported (less than 1%) were elevations of creatinine and the presence of casts in the urine.

CENTRAL NERVOUS SYSTEM—headache or dizziness were reported occasionally (less than 1%).

GENITOURINARY—moniliasis or vaginitis were reported occasionally (less than 1%).

MISCELLANEOUS—diaphoresis and flushing were reported occasionally (less than 1%).

Other rarely observed adverse reactions (less than 0.1%) include leukocytosis, lymphocytosis, monocytosis, basophilia, a decrease in the prothrombin time, jaundice, gallbladder sludge, glycosuria, hematuria, anaphylaxis, bronchospasm, serum sickness, abdominal pain, colitis, flatulence, dyspepsia, palpitations and epistaxis.

DOSAGE AND ADMINISTRATION: Rocephin may be administered intravenously or intramuscularly. The usual adult daily dose is 1 to 2 gm given once a day (or in equally divided doses twice a day) depending on the type and severity of the infection. The total daily dose should not exceed 4 grams.

For the treatment of serious miscellaneous infections in children, other than meningitis, the recommended total daily dose is 50 to 75 mg/kg (not to exceed 2 grams), given in divided doses every 12 hours.

Generally, Rocephin therapy should be continued for at least two days after the signs and symptoms of infection have disappeared. The usual duration is 4 to 14 days; in complicated infections longer therapy may be required.

In the treatment of meningitis, a daily dose of 100 mg/kg (not to exceed 4 grams), given in divided doses every 12 hours, should be administered with or without a loading dose of 75 mg/kg.

For the treatment of uncomplicated gonococcal infections, a single intramuscular dose of 250 mg is recommended.

For preoperative use (surgical prophylaxis), a single dose of 1 gm administered 1/2 to 2 hours before surgery is recommended.

When treating infections caused by *Streptococcus pyogenes*, therapy should be continued for at least ten days.

No dosage adjustment is necessary for patients with impairment of renal or hepatic function; however, blood levels should be monitored in patients with severe renal impairment (*e.g.*, dialysis patients) and in patients with both renal and hepatic dysfunctions.

HOW SUPPLIED: Rocephin (ceftriaxone sodium/Roche) is supplied as a sterile crystalline powder in glass vials and piggyback bottles. The following packages are available:

Vials containing 250 mg, 500 mg, 1 gm or 2 gm equivalent of ceftriaxone; piggyback bottles containing 1 gm or 2 gm equivalent of ceftriaxone; bulk pharmacy containers containing 10 gm equivalent of ceftriaxone (NOT FOR DIRECT ADMINISTRATION).

Also supplied as a sterile crystalline powder as follows:

ADD-Vantage Vials** containing 1 gm or 2 gm equivalent of ceftriaxone.

Also supplied premixed as a frozen iso-osmotic, sterile, nonpyrogenic solution of ceftriaxone sodium in 50 mL single dose plastic containers,† as follows:

1 gm equivalent of ceftriaxone, iso-osmotic with approximately 1.9 gm dextrose hydrous, USP added.

2 gm equivalent of ceftriaxone, iso-osmotic with approximately 1.2 gm dextrose hydrous, USP added.

NOTE: Rocephin in the frozen state should not be stored above -20°C.

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